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ABSTRACT

This report describes activities of a workshop conducted for fourteen health education practitioners and administrators from a number of different hospital and health care settings and geographical regions to appraise the state of patient education programs. The initiation and growth of patient education programs in a variety of health care delivery settings are described. The bulk of this report is contained in the appendixes, which include the following: a paper, "An Overview of Patient Education," by Dr. Jeannette Simmons, Harvard School of Public Health; a listing of regional sources of patient education materials; and seventy pages of a variety of patient education materials, such as a diabetic patient education program, teaching guidelines for the ostomy patient, and program design components for planning for specific patient education programs. (BL)

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PATIENT EDUCATION WORKSHOP: SUMMARY REPORT*

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Center for Disease Control
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Patient Education Workshop

On January 26 and 27, 1976, the Bureau of Health Education, Center for Disease Control, brought together 14 health education practitioners and administrators from a number of different hospital and health care settings and geographical regions. The session was one of many efforts by the Bureau to appraise the state of patient education and to determine what is expected from and what can be provided by the Bureau in this health education area.

The summary report was written by Dr. Jeannette Simmons, under Purchase Order No. 56786, and reviewed by the other workshop participants.

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SUMMARY REPORT

The initiation and growth of patient education programs in a variety of health care delivery settings were described by participants in a Patient Education Workshop held at the Center for Disease Control on January 26 and 27, 1976. The general characteristics of these programs are presented in Table 1. The participants detailed specific differences in each location, but several common threads emerged for each stage of program development. These commonalities are identified along with some explanations of how and why differences occur.

Initiation of a Patient Education Program

In all locations, the program began with a concerned physician, board member, or administrator who was responding to outside stimuli. The impetus included (1) new demands for patient discharge planning, (2) funding available from Regional Medical Programs (RMP) or other Federal sources, (3) professional contact with an educator and reading of the literature, and (4) the requirement in the medical-nursing audit part of the Joint Commission on Accreditation of Hospitals' (JCAH) review criteria.

The growth of the idea from an individual initiator to an institution-wide program required the development of support among the leaders in each location. These include the health agency administration, the medical staff, nursing staff, and other health workers. The groundwork of exploration and interpretation to determine where and when to start a specific planned educational effort and to develop the operational plan was estimated to require 9 to 12 months. During the planning period supplementary activities are carried out; these include the development of bibliographies, formal staff training sessions, and employee health education. The time variation depended upon the size and complexity of the institution or agency and whether the person selected to direct the program was from the "inside" or "outside."

When a person who is already known and respected in an organization is appointed patient education coordinator,[1] less time is required to obtain the necessary agreements on what, where, and how educational procedures will be introduced into the operations. The examples cited indicated that a senior member of the nursing staff with educational preparation was usually chosen for this responsibility. The position remained administratively in the nursing department. This pattern was reported for hospitals under 500 beds.

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[1] Many different titles are used for the person assigned institution-wide patient education program responsibilities; the title used for this person throughout this report will be patient education coordinator.

TABLE 1. -- Settings and characteristics of patient education programs as described by workshop participants

Organization	Type of Institution	Size	Location of Patient Education in Institution	Patient Education Coordinator	Year Initiated	Initiator of Program	Source(s) of Funding
Baptist Hospital Pensacola, FL	General community hospital	500 beds	Decentralized to special care units	Clinical nurse specialist (Master's degree)	--	Administrator	Hospital's general bed rate
Carle Clinic and Foundation Hospital Urbana, IL	Group practice and hospital	88 private physicians; 235 beds	Patient education in nursing service, teaching decentralized	Nurse educators (1-1/2)	1973	Director of nursing and medical director	Out-patient fee for services; hospital's general bed rate
Greenville Hospital System Greenville, SC	Hospital system: 5 acute; 1 rehabilitation; 1 psychiatric; 1 nursing home	1100+ beds	Department of nursing and patient education discharge planning committee	Nurse educators (2)	1973	Staff	HEW 5-yr. grant; gradual shift to hospital
VA Medical District 14 Ann Arbor, MI	VA medical district 14: 4 hospitals	1 general: 220 bed 2 medical affiliates: 430 beds 704 beds 1 psychiatric: 1240 beds	Responsible to medical district director and central office dept. of medicine and surgery	Health education specialist	1975	Chief medical director, dept. of medicine and surgery, VA central office	Federal VA central office
USPHS Hospital Staten Island, NY	USPHS, general hospital	500 beds	Office, director of nurses	Public health education specialist	1967	Hospital's medical director	Federal

TABLE 1. (Continued)

Organization	Type of Institution	Size	Location of Patient Education in Institution	Patient Education Coordinator	Year Initiated	Initiator of Program	Source(s) of Funding
Los Angeles County Health and Hospitals Dept. Regional Office Los Angeles, CA	System: primary care centers and hospital	770,000 population	Community medicine dept. in medical school; under each clinical chief	Public health education specialist	1973	County dept. of health services and chairman, dept. of community medicine	RMP HEW county
Group Health Corp. of Puget Sound Seattle , WA	HMO hospital plus 8 area ambulatory centers	200,000 enrollees	Department responsible to administrator	Patient education specialist and management consultant	1971	2 Board members	HEW grant and 2 HMO fees
Mt. Sinai Hospital Hartford,CT	Consortium of 3 hospitals; expanded to 8 hospitals	355 beds	Consortium patient education committee for 4 hospitals, responsible to chief, ambulatory care	Public health nurse	1973	Chief, ambulatory care and community medicine	Blue Cross grant to consortium
St. Mary's Hospital San Francisco, CA	General hospital	500 beds	Office, responsible to hospital administrator and medical director	Public health education specialist	1973	Medical director	RMP; hospital supplement
Kennebec Valley Regional Health Agency: Project RISE Waterville, ME	Project RISE; 1 of 10 projects of the regional health agency	9 consortium hosps. (23,000 beds); the state mental health institution; the VA central hospital; and 8 nursing homes	Patient education program of Project RISE responsible to project director and policy committee of consortium	Project director	1974	Developed from needs assessment in consortium institutions	Direct hospital funding

In the larger patient care settings represented at the Workshop, the patient education programs were staffed by coordinators who were public health education specialists. They came to these positions from outside the hospital staff. Their approach to program development was to work through existing organizational committees (e.g., Patient Care Committee) or to form new ones (Patient Education Advisory Committee) to determine what and how educational services would be instituted. Although the process of legitimizing the program through the decision-making bodies of the institution by the outsiders required more time, these coordinators reported that the discussions provided a means of sorting out different interpretations of the program and broadening the base of support. Under either condition, the participants agreed, it was advisable to formalize the decisions about how the program will operate. If this is not done, much of the "institutional knowledge" can be lost when staff changes occur.

Implementation of a Patient Education Program

The patterns of how patient education services are provided ranged across the continuum from the clinical nurse specialist assuming total responsibility for delivering the education, to a health care provider being delegated specific educational responsibility based on the decision of a multidisciplinary team assessment conference. The latter depends on an institution's deciding that education is a primary function of all health workers and an essential part of patient care. The participants cautioned that the pressures to demonstrate what can be accomplished through patient education may lead the patient education coordinator into a direct service role of providing the education through counseling and classes rather than making it a function of all health care providers. This undesirable occurrence can be avoided in two ways: (1) Invest time at the organizational level to set policies about how the educational service will be built into the operations and (2) involve the health workers who will deliver the service as active partners in shaping the program. When these individuals are involved in determining where the program is going, what it is trying to accomplish, and what priorities should be set, then orderly steps can be taken to assign responsibilities and to coordinate the total effort.

Scope of Program

The participants reported that at the outset a well-formulated patient education program should be built on the basis of what the professional staff agrees should be the basic therapeutic regimen for patient education in each illness category. This must then be implemented through an organized assessment of the individual's social, emotional, and educational needs and resources; a determination of

how best to adapt the standard procedures to the individual's needs; and a delegation of responsibility to the various health workers to provide the learning experiences. The plan should include monitoring of the program to assess the effectiveness of the educational activities with feedback to the staff so constant adjustments can be made. It is also essential that this information be made available to others for further guidance of the patient and family in self-care after discharge from the hospital if this is needed. As the concept of informed patients becomes less of a threat to administrators and health professionals, other approaches may become important aspects of patient education programs.

Educational Approach

The development of the educational plan described above usually requires changes in the current educational activities. One frequently finds the educational approach used by health professionals as one in which they follow the way they were taught (e.g., the "medical model"). This model includes instructing the patient about the etiology of an illness, the symptoms to observe, and the therapeutic regimen to be followed. The educator working with other health workers has to find ways of re-orienting this approach from what the patient "ought to know" to one which incorporates into it what the patient thinks he needs to know and what aspect of the illness or its management is of concern to the patient. The patient's readiness for specific information will vary over time; thus, different sequential exposures must be developed for the patient and often with another member of the family. In nearly every situation the patient needs more than one educational exposure to grasp the implications and details involved in the management of a disorder.

Initially the staff may use educational materials published by other organizations or commercial firms. However, as the staff accumulates information about their patients' needs and the specific therapeutic regimen prescribed by the professionals, they develop their own information sheets and audio-visuals so these will be consistent with the verbal instructions given. The participants indicated they found examples from other patient education coordinators very beneficial in illustrating ideas for their health professionals, but they always want the teaching materials to be tailored to their situation.

Involvement of Others

All of the program described utilized a multidisciplinary approach to program development and implementation; however, the degree of involvement varied. In the situations where patient education is located

within the nursing department, the nursing staff is charged with the major responsibility for assessing the patient's needs and determining when to refer the patient to the dietitian, social worker, etc. In other organizational arrangements, a multidisciplinary team does the assessment of needs and plans the educational activities as part of the regular health care services. The latter arrangement provides perceptions about the patient's concerns, lifestyle, and resources from the vantage point of different disciplines and personalities. What is elicited varies with the interpersonal relationship established by each health worker with the patient.

Among the participants' descriptions of how one plans, organizes, and implements, two different patterns emerged. Some view the program development from a systems perspective with decision-making, communications, and actions being determined by those responsible for the overall organizational structure. Others proceed to develop program by program so that the decisions and actions made are confined to the persons involved in each subdivision of the total organization. In either approach the administration must legitimatize the program effort. The involvement of top management and the chiefs of medical staffs increases support and participation in the program.

Referrals for Education

In the community hospital with private physicians the number of referrals for special educational services is dependent upon a personal trust relationship being established which is often developed through involvement of the physicians in the planning. In smaller hospitals this often occurs because working relationships were established by the patient education coordinator in a previous role within the hospital. When the number of hospital staff physicians is very large, the referrals are initially developed through involvement of key, influencial physicians in the education planning process. Over time the idea spreads by physicians talking to other physicians informally and in staff meetings for physicians and through the incorporation of patient education into discharge planning where medical and nursing audits look for specific actions as part of patient care.

Staff Preparation

Although all health workers are "assumed" to be patient educators, their professional preparation often has not included the skills required to assess educational needs and to devise interventions appropriate to the learning needs of patients with different health conditions. Thus, a major component of a patient education program is staff development, and arrangements for this require carefully

staged formal and informal non-directive learning experiences for different categories of health workers. One opportunity to provide such education is during the planning process when a patient education program is being developed within the various units of the health care institution or organization.

The participants expressed a need for an effective and acceptable way of assessing the competencies of the health staff to perform educational tasks. In developing staff competencies the following questions need to be considered: What kinds of educational methods and skills can be communicated in written form? Which ones require observation of staff? What types require more intensive training and consultation? A major concern was expressed about how to incorporate evaluative measures into program development.

Accountability and Monitoring

Several of the participants reported they have instituted regular feedback from patients and health workers about the educational activities. These vary from subjective evaluations of what was accomplished to an analysis of changes in patient behavior with regard to self-care and utilization of services.

Ongoing monitoring of programs is needed in order to improve an educational program and to determine more adequately the cost of providing services. This examination should be directed toward learning which educational intervention (when, where, and with whom) proves more successful than others. Careful examination of what is being provided along with good feedback from the patient can contribute to wise decisions about program changes. The number and types of staff involved in patient education need to be determined by examining the following questions:

- When is the education part of an ongoing service or routine care? (e.g., knowledge of drugs, dosage, administration, and precautions)
- When does the education involve considerable content beyond the capacity of the immediate care provider in the course of usual work? (e.g., exchange concept for diabetics)
- When is the education directed toward the development of a skill and the institution of a continuing practice or behavior as part of a therapeutic regimen? (e.g., preparation and administration of insulin, management of supplies)
- When does the educational content need social support? (e.g., meal preparation, peer smoking behavior)

Answers to the above questions can help specify who should do the education, when, and with what methods and tools.

Although the participants agreed there is a need for systematic appraisals of patient education programs, they cautioned against attempting to "prove education's effectiveness" with experimental studies in a practice setting. The assignment of patients on a random basis into experimental and control groups is exceedingly difficult when the number of patients available is small and the characteristics of the patients, the factors which influence the course of the illness condition, and the variations in patient management are numerous. It is perhaps more realistic to rely on research centers to conduct the experimental studies and for the practitioners to maintain records which describe the outcomes of educational efforts in terms of individual patient behavior change and overall improvement in patient management. If patient outcome measures are to be evaluated in a practice setting, there needs to be funding for developmental programs for 3 to 5 years. The literature has a number of studies reported which substantiate the cost-effectiveness of education in patient care.

The educational procedures undertaken along with the health worker's assessment of the patient's understanding and ability to manage certain aspects of self-care are being reported in the patient's medical record. In institutions which utilize the problem-oriented medical record (POMR), patient education is given explicit attention. In others the discharge and planning notes with regard to patient education are being examined as part of the medical and nursing audits.

Skills and Competencies of the Coordinator

The skills and competencies of the patient education coordinator were described by the participants as varying with the size and type of setting. The larger and more complex institutions and organizations require that more time be spent on managerial functions to coordinate the many persons involved and to develop and maintain communications with regular feedback throughout the many networks in the institution. However, the process of program development is the same in all settings so the major difference is the manner in which the functions are carried out.

In order to successfully formulate and gain acceptance of new policies in an organization, a person must have knowledge of the decision-making structure and how it operates. The larger and more diffuse organizations present complicated problems of analysis in terms of identifying the leadership and in using influence. To successfully maneuver through such complexities, in order to obtain program support across the many networks, requires competencies in analytical and organizational areas. The program justification must be well formulated and presented on the basis of what is feasible, timely, and attractive to the organization.

Program planning requires skills applicable to all settings. These include knowledge of how to work with committees in the selection and recruitment of members; determination of goals; agenda building; development of appropriate background information; report writing; follow-up procedures; and solicitation of feedback.

The coordinator should possess facilitation skills necessary for effective problem analysis, decision-making, and problem solving. These processes require a person who is creative and receptive to input from many sources.

Throughout the planning and implementation stages of a program the coordinator will need to have knowledge of the educational process with an extensive repertoire of methods and strategies. It is crucial to effective program development and accomplishments to select appropriate methods which can be applied by the available staff to different health care situations. These competencies will apply equally to the coordinator who is working with a multidisciplinary group of health workers in their development of educational programs and to the health worker who is focusing on the learning experience to be provided patients.

Implied in the above are written and verbal communications skills as well as an understanding of ways interpersonal relationships are established and maintained. It is also important to have a knowledge of the health field in terms of the patterns of organizations, professional orientations, and role relationships and a knowledge of the culture of hospitals.

The special managerial skills required are interviewing, developing forms and work plans, as well as understanding reimbursement and budgeting.

Finally, professional assertiveness is essential in order to introduce new concepts with broad-based support.

Administrators selecting staff should be aware of the nature and scope of the capabilities needed. The complexities of the health care delivery organization, illness management, and the educational process require that persons be selected who have mature judgment and extensive preparation. In addition they need enormous patience and persistence and endurance to get activities underway and sustained. They must have administrative and medical staff support and sufficient funds for secretarial assistance and materials development.

Benefits

There were frequent references to the increased patient satisfaction expressed about medical care when appropriate patient education services are provided. The program was described as an important "attraction" for hospitals located in a "competitive market."

The development of a patient education program changes the atmosphere and morale in a hospital. The process provides an increased awareness of total patient needs, educational opportunities which have been missed, new methods for delivering service, and the standardization and formalization of many health care procedures.

The team or multidisciplinary approach provides for the kinds of interactions whereby the professionals become involved in learning from each other in a non-threatening manner. The focus on the patient and the problems from this perspective changes the situation in terms of hierarchical role relationships.

All programs, regardless of where they start in providing an organized patient education program, move toward a concern and action for an integrated inpatient, outpatient, community follow-up approach. When the system includes all of these services, the patient education coordinator or a patient care coordinator has to work for understanding, cooperation, and the establishment of communication networks for effective follow-through among providers. In the situations where the hospital entity has patients being followed in the private physician's office and where the community resources have not been identified as part of total patient care, a great deal of education inside and outside of the hospital has to be undertaken. Careful planning is needed to assure consistency of advice and for effective reinforcement to obtain adherence to treatment regimen.

Costs and Budgets

The source of funds for each location is presented in Table 1. The programs which have been funded through Federal grant money are most concerned about continued support. In the institutions where patient education is part of nursing service, there has been no problem of adding the cost into the daily bed rate.

Where separate identifiable patient education budgets exist, the amount reported varied from a high of $150,000 for an inpatient, outpatient, and community education program serving a health maintenance organization (HMO) with an enrollment of 200,000; to a low of $30,000 for one

staff coordinator and a secretary in a 500-bed hospital.

Third-party arrangements have been successful in some outpatient settings for special classes and indepth educational counseling. These include medicare, medicaid, Blue Cross, and one private insurance company. The educational fees charged for outpatient special classes and counseling services varied from $10 to $20 per session. Persons attending weight reduction classes and other special education groups are charged a total service fee. A patient education program for hypertension in an outpatient clinic was reviewed to determine the average amount of time each health professional devoted to patient teaching. The cost was computed by multiplying each of the staff member's amount of time by his/her hourly salary. The mean cost was $27 per patient. An additional $30 was included for supervision and clerical support. These educational services extended over an average of five visits; patients took approximately 8-9 weeks to complete the program. However, these mean figures obscure the wide variation in time spent with each patient and consequently the cost of teaching any given patient.

Suggestions for the Bureau

The participants identified several areas of agreement about where the field is in the development of patient education in health care delivery settings. They also suggested some actions which they felt could enhance current efforts and stimulate further growth:

A. Reimbursement

In the area of reimbursement, the participants agreed that the method of payment for patient education services should be as follows:

1. When the educational services are part of normal good patient care which would include patient orientation to the health care setting, developing an understanding about the illness condition, and how to manage the therapeutic regimen, the charges for these services should be a part of the total daily bed rate.

2. When a patient's condition requires special educational services beyond the routine care, the patient should have the option of "elective education;" this would be a specific additional charge. This is most likely to occur with therapeutic regimens which require changes in life-style and hence needing a more extensive education plan.

3. In the outpatient settings, the educational services would be identified in the clinic charges as part of a total visit fee or as an extra depending upon the nature of the service.

The group agreed that actions should be undertaken immediately to establish criteria for third party payers to use as a basis for determining reimbursement for patient education services. Several criteria were suggested as a basis for determining whether or not a patient education program exists. These included: a policy statement with institution-wide support; a professional person assigned responsibility for directing the service; program documentation of objectives, procedures, and strategies to interrelate the activities of all persons providing learning experiences; and systematized methods of assessing the outcomes in terms of patient satisfaction, change of behavior, and the quality of the interaction between patients and health workers.

B. Consultation Service

The participants urged the Bureau of Health Education to take the leadership in developing a consultation service on patient education for health care delivery institutions and organizations. Many false expectations and staff frustrations could be avoided if an expert were called upon prior to the setting up of a patient education program. The persons selected for this consultant role should have a thorough understanding of the different patient education models which have been developed. They should also be skilled in assisting administrators in examining their needs and resources and on the basis of this analysis determine the appropriate organization, staff, and budget for their patient education program. In the development of a nationwide network for consultation services a group of 15 or more persons with extensive experience should be selected from throughout the country. They should be brought together in a working conference where they could enhance each other's knowledge about the field and arrive at some agreed upon guidelines for use in the consultation service.

C. Preparation of Health Workers

The development of patient education programs could progress most rapidly and effectively if health workers were prepared in the theory and application of patient education and interdisciplinary teamwork. This education should be included in the professional schools and as part of continuing education programs. The Bureau should work with academic institutions and the Bureau of Manpower to promote these concepts.

D. Guidelines and Instruments Needed

Although patient education programs are proliferating and the educators are demonstrating an increased sophistication in their implementation, the participants agreed there is a tremendous need for the refinement of the procedures and methods throughout the entire process. The patient education coordinators would like to

have more documentation and guidelines on which to base their judgments in the entire program development process. This includes effective ways to assess the resources and activities in an institution; determining where to start and what area to move to next, as well as to know how to maintain a program or decide when to phase it out.

The discussion sessions brought out a number of valuable approaches which are being used by the participants and by other coordinators they know. However, they all indicated that this knowledge was not widespread and one only learns about these by accident. They suggested that a more systematic means of disseminating programmatic information should be developed.

Everyone agreed that there is still insufficient documentation of services rendered, how they are carried out, and the barriers and constraints to instituting effective learning experiences. It was pointed out that one of the most difficult tasks in patient education is to determine which patients are ready to make changes in their lives. how these patients can be distinguished from others, and what are the most effective ways to teach them. The practitioners would like to have some research done in these areas and some instruments developed to guide their assessments and judgments.

The participants also expressed a desire for the development of instruments and guidelines for planned evaluations which could provide evidence of "success" and outcome benefits in terms of an impact on health and utilization. The local practitioner would like available "on the spot" consultation as to how evaluations could be conducted within the constraints of the ongoing operation.

In summary, the participants look to the Bureau to develop criteria, guidelines, and material policy which recognize health education as an integral part of health care delivery and which assure the provision of appropriate health education services to different population groups by skilled and competent individuals.

APPENDIXES

Prior to the Workshop, a copy of Dr. Jeannette Simmons' paper "An Overview of Patient Education" was sent to the participants for their consideration in preparing for the Workshop. This paper is included as Appendix A. Additionally, the participants in this Workshop were asked to bring, as a base to begin discussion, patient education materials used in their respective health care settings. A full list of these materals follows as Appendix B. Some materials in their entirety and excerpts from others are included as Appendix C. They are included to promote discussion about patient education among readers of this report and the Workshop participants. Inclusion of these materials should not be interpreted as endorsement or qualitative evaluation of them by the Bureau of Health Education, its Community Program Development Division, or by the Workshop participants.

APPENDIX A

An Overview of Patient Education[1]

The following discussion is a summation of ideas on patient education from a review of the literature, information collected from innovators in the patient education field, and statements made by influential persons in professional and institutional organizations.

Definition of Patient Education

Patient education is defined by the Joint Committee on Health Education Terminology (American Public Health Association and Society of Public Health Education) as "those health experiences designed to influence learning which occurs as a person receives preventive, diagnostic, therapeutic and/or rehabilitative services, including experiences which arise from coping with symptoms; referrals to sources of information, prevention, diagnosis, and care; and contacts with health institutions, health personnel, family, and other patients" (2).

In more specific terms, one recognized authority states, "Patient education should consist of organized health educational experiences, planned by physicians, professional health workers, and the patient himself to meet the patient's specific learning needs, interests, and capabilities, and offered as an integral part of the patient's total health care" (3).

The above definitions focus on the patient and the health care providers. The role of the health care delivery system and its influence on the health behavior of patients need to be added. Studies have been reported in the literature in which an educational problem-solving approach involving health workers, consumers, and administrators resulted in the identification of system problems; when changes were instituted, there were measurable improvements in both utilization and patient management of the illness.

A patient education program must be planned, supported, and implemented in a manner in which all complexities inherent in total patient care are considered. These include the interaction of the complexities present in the health and medical care delivery system, the illness entity, and the educational process. Because many decision-makers and health professionals are not aware of the requirements for sound and effective

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[1] Prepared by Jeannette Simmons, D.Sc., Harvard School of Public Health, Boston, Massachusetts 02115, for consideration by participants in the Patient Education Workshop, Community Program Development Division, Bureau of Health Education, Center for Disease Control, Atlanta, Georgia 3033, January 26-27, 1976.

[2] New Definitions: Report of the 1972-1973 Joint Committee on Health Education Terminology. Health Education Monographs No. 33, p.67, 1973.

[3] Ulrich, M., Kelley, K. M. Patient care includes teaching. Hospitals 46: 59-65, April 1972.

education which can influence patient behavior, a major thrust of the patient education program needs to be directed toward these individuals.

Level of Function of Patient Education Programs in the United States

The development of an identifiable patient education program which is institution-wide rather than illness specific has grown substantially since about 1972. Preliminary examination of recent data collected by the American Hospital Association (AHA)(under contract no. 200-75-0542 with the Bureau of Health Education) shows a substantial growth in the patient care settings where one experimental/demonstration program proved successful.

It is apparent that most hospitals are increasing their patient education efforts; however, these are usually around specific aspects of patient care. Many institutions are developing orientation programs for patients to better understand hospital procedures, greater specification of what is to be taught for specific illness conditions, and increased use of educational materials. These developments can prove beneficial or detrimental to the patient education movement. The one episode educational activity can mislead the health care system into believing it has an educational program and invest too many resources in a product rather than setting in place a process that adapts the educational methods and materials to the needs of the patients and the resources of the institution and the community. Technical assistance should be provided these institutions so they can build upon their current efforts and devise a broader approach which will enhance outcomes without a greater expenditure of funds.

An inherent problem in patient education is the short time available for a hospitalized patient to learn all the facts and skills necessary to manage the illness condition. An additional factor is that until the patient is away from the institutional setting and starts to implement what was taught, he is not aware of the problems of management. The nature of many illnesses requires too many extensive changes to be taught within the time the patient is available in the hospital. Thus an effective hospital-based program must plan the educational experiences with inpatient, outpatient clinics; physician offices; and community home care resources. The communication channels which must be developed to provide a comprehensive educational program are extensive. There is a need for interchange and feedback if the progress and problems of the patient are to be dealt with on a consistent basis by all who are serving in the provision of health care for the patient.

The medical-nursing audits as well as the increased use of the problem-oriented medical record offer an excellent opportunity to build in patient education. Both of these avenues should be explored in locations where patient education programs exist to ascertain how such procedures could be effectively developed and implemented.

The most typical hospital to initiate an institution-wide patient education program is the community teaching facility (not a medical center) of 300- to 800-bed size. The program is usually initiated by a member of the medical staff who became committed to the concept and then convinced the hospital administration that such a program should be supported programmatically if not financially at the outset.

Personnel Involved

Patient care procedures are performed by all personnel who have direct or indirect contacts with the patient. These contacts bring implicit and explicit information, attitudes, and feelings to the patient. Hence the educational aspect of care will be provided in a positive manner only if personnel and staff are prepared to provide it. This preparedness depends upon: (1) being sensitive to the needs of the patient as exhibited in patient behavior (e.g., questions asked, requests made, anxiety expressed); and (2) being able to meet these needs, once they have been identified, through the application of specialized skills and expertise.

In the direct delivery of educational programs for specific health conditions, the most frequent persons mentioned in the literature are nurses, dietitians, and pharmacists. A growing number of physicians are writing about their efforts in educational programs for specific illnesses. These are primarily pediatricians, internists, and surgeons. Programs also have been developed by media specialists and public relation officers around a "fixed message" with the use of taped telephone messages, closed circuit television, and videotapes.

The planned institution-wide programs involve different health workers depending upon the nature of the health condition and the needs of the patient. These programs have involved social workers, clergy, physical therapists, and other health workers as part of the health team. There appears to be a movement for former patients and volunteers to be included in patient education both through referrals to mutual aide groups and by inviting members of these groups to participate in meetings of the team when they are planning and implementing a patient's learning experience.

Education specialists serving in hospital-wide education programs function as coordinators and facilitators. Much of their effort is directed toward assisting other health workers to increase their understanding of learning theory and educational skills so they can provide more effective learning experiences for patients and families. The education program coordinators do not engage in direct patient teaching. They assist in the diagnosis of the educational needs (specifying the learning experiences) and provide in-service education. They also provide the organizational and group process skills needed to bring health workers together in problem-solving groups.

Some facilities which do not believe they can justify financially the full-time services of an educational specialist for the various treatment and rehabilitation facilities in the community have considered combining their financial resources and employing such a specialist. This sharing of personnel and staff could contribute to a more comprehensive educational program with continuity.

Resources Available

The availability of audiovisual equipment in hospitals is very extensive. An AHA survey conducted in 1974 revealed that of the 83.2 percent hospitals responding, 91.7 percent had motion picture projectors; all had 35-mm slide projectors with two-thirds owning Kodak carousels. Slightly over 50 percent had some type of videotape recorder with the variations in size and type of reel ranging over five different units. Audiotape recorders with slide synchronizer were available in 23 percent of the hospitals and another 40.1 percent had such recorders without synchronization. Another 6 percent had an open reel audiotape recorder with slide synchronization and 18 percent without it. Thus almost all have audiotape recorders. This survey did not include closed circuit TV equipment; however, a later survey in the process of analysis will provide this information.

All of this available equipment has had an effect on the development of "educational messages" for patients. One observes in many settings that the media has been the only message far too frequently. Thus an idea grows out of making a videotape or recording rather than starting with an identification of an educational need and then determining how that need can be met. Health professionals need to be reminded that learning theory must still be in control of the devices it uses to present information. The effective use of educational technology requires more teacher preparation than direct teaching since one cannot discover and correct misinformation or wrong interpretations by the student because there is no direct feedback from learner to teacher.

Technology does offer a change in the style and time-dimensions of education and thus it can be made available at the user's convenience as opposed to an instructor's schedule. When educational technology is viewed as merely a tool of a well-defined education program, appropriate uses can be developed. The promotion of commercial interests

in this field has often not been consistent with the most economical and efficient use of these resources. In the literature, examples are cited whereby newer media were planned as part of a total program effort and community resources were donated to assist in the development of inexpensive and highly situationally specific educational materials.

Pamphlets, booklets, charts, posters, slides, movies, tapes, and recordings have been produced in great abundance by voluntary and professional organizations and an ever growing number of commercial firms. Many of these can serve a useful purpose by providing background information; selection should be on the basis of educational, cultural, and social characteristics of the patient and family. Other well-prepared materials can be used with professional groups in a hospital as examples of the content to be covered and how to present it in creative ways. This can be reviewed prior to developing a group's own educational materials which specify what they want their patients to know and do. The development of situationally specific materials that compliment and support the verbal messages given by health workers is important when many new terms and directions are given. The process of development of such materials provides the health experts with a focus to resolve different patterns of advice among them. The pretesting of these materials with patients and families brings feedback to health workers on the ways messages are interpreted by patients and if they meet the patients' needs.

The availability of space for group teaching or even private one-to-one counseling is often a major barrier to the development of learning experiences for patients. This may be true for the entire hospital operation or in specific service units. The planner must consider the condition of the patient for movement and in some situations make arrangements for transporting the patient to the educational setting. Bringing together a group of patients with a similar condition may be difficult if those individuals are located in several different sections of the hospital.

Priority Program Areas

The educational program that is most frequently reported as using a multidiscipline approach and which has planned sequential learning experiences is diabetes. The need for self-care is so obvious in this condition that it is immediately identified for an educational program. The literature also reveals that the traditional instructional approaches have not resulted in improved patient compliance. Although patient educators who have well-planned education for diabetic patients are citing anecdotal evidence of improvements with different educational methods, the large number of situational factors that affect the diabetic condition precludes obtaining statistically valid data when the number of patients they serve each year is small. Thus far they have documented the changes in illness episodes of individual patients by comparing before and after medical records.

The other major area receiving attention is the problem of poor patient compliance in hypertensive patients. The National Heart, Lung, and Blood Institute is supporting research in this area. Five locations have been exchanging information about their research, and in at least three of these studies educational specialists have been included on the research team.

The availability of cancer funds for community programs is beginning to have an effect in hospitals. There appears to be a growing number of educational programs for the cancer patient and family. Another strong influence in the development of these programs has been discussions of the "death and dying" issue along with the "patient's right to know."

The orientation of the patient to the hospital has been extensively used with a range from a popularized pamphlet, describing the personnel, services, and "rights" of the patient, to taped messages via telephone or closed circuit television. The literature reports a few studies in which a favorable difference in behavior among young children was observed among those who had educational preparation prior to hospitalization.

The guided group discussion has for many years been a common method used in dietary instruction. This can provide effective learning if the group size and similarity of patient needs and capabilities are controlled. The instructor needs skills in eliciting information from the patients about their concerns and interpretation of the material presented. An effective leader can encourage the discussion of problems and suggestions for practical solutions. The characteristics of the patients available for group instruction will also enhance or complicate the learning process. Many health professionals are not prepared to effectively lead this type of discussion and often the discussion falls into personal problems and questioning of medical advice.

Small group process discussions in which the group members define their concerns, discuss alternative solutions, and develop a group decision to take an action are difficult to develop in the hospital inpatient setting. The long term care patients with cancer and some heart conditions have been involved in these "mutual support" groups. The outpatient setting has been used more frequently for the patients with dietary problems, hypertension, and arthritis.

As discussed earlier, the most common educational technique used is the mass media approach through pamphlets, taped messages, and audio-visual presentations. In recent years there has been more individualizing of the content of the messages by the local staff. In some locations a program has been organized to follow-up the general material with individual or small group sessions and in others to at least encourage questions or feedback on what the patient has obtained from some form of media.

Members of such self-help groups as Alcoholics Anonymous, Ostomy Association, and Reach for Recovery are being used by hospital staffs to provide patients with another person who has faced a similar condition. In this "coaching" relationship the patient can learn the practical adaptations to a condition and receive support and encouragement.

Consultation to other staff workers on educational program development and materials selection is a method used by the education specialist to further patient education. In addition some in-service education sessions are organized to improve communication skills, assess patient educational needs, and plan learning experiences.

The use of the team approach is perhaps the most recent method introduced in which all the health care providers participate in assessing the patient's needs, capabilities, concerns, social conditions, and resources as they relate to the development of an educational plan for the patient. The members of the team meet to exchange information elicited from the patient. This has greatly increased the total understanding of a patient and the situational factors affecting the patient's ability to manage the health condition. This interchange provides a basis for determining what learning experiences the patient and family need, how this can best be instituted, and who will take what actions. A progress and discharge evaluation session is held to decide what follow-up actions are needed and how these can be carried out. The length of a team meeting varies from 15 to 45 minutes depending on the complexities of the problems being discussed.

When the approach to patient education is focused on the learner rather than on the content or instructor, the health worker must accept the premise that the patient is the decision maker. This requires starting with the patient, identifying the health goal he wants to achieve, what is to be learned, the alternatives available to meet the educational needs and behavior changes desired, and how the patient can evaluate his own progress. The process also involves including others (family, employer, friends) to assist the patient in attaining these goals and to finding the most effective use of each member of the health team in helping the patient to realize the goals set.

A practical method suggested for use along the entire patient-provider continuum is obvious, but unfortunately rarely used; that is, the patient should be supplied with "paper and pencil" so notes can be made of what is being said about medication, diet, appointments, etc. Patients should be accompanied through the health care system by the person responsible for carrying out the regimen rather than being told what was found and what needs to be done in a summary session.

A patient care record has been introduced for pediatric patients so mothers can keep up to date on the health care given and a history of the child's illnesses. There is a need to extend this to all patients. In addition, patient care diaries have been introduced in some illness conditions to increase the specificity of what the patient tells the physician and to improve the patient's observation of what actions are taken and what is happening.

Accountability Measures

The literature reports the growing expressed concern of the public, patients, and organizations for patient rights and informed consent. The impact from this on patient education cannot be directly assessed, but it must be assumed to be an important factor in the present patient education efforts.

The medical and nursing audits have a potential for interpretation whereby good medical care should include education of the patient. The literature reports some recognition of this. The Professional Standards Review Organizations (PSRO) also have an opportunity to include education as a measure of quality of care. The growing concern with compliance as an essential aspect of quality of care brings the educational responsibilities into sharper focus. Finally, the consumer movement and its role in the review process for the Joint Commission on Accreditation of Hospitals have begun to influence patient education. The Commission specifically looks for the discharge information given to patient and family.

Benefits Accrued Through Evaluation of Innovations

The entire field of health education could benefit if evaluation tools were developed which examine the educational process for the best or better ways of providing learning experiences. Evaluations related to behavioral outcomes in terms of an individual taking recommended actions could strengthen support for health education.

A concerted effort to specify the actions which are planned and the responses made to events which occur in the initiation and implementation of a patient education program would move the health education field from dependence upon the unexplained skills of a practitioner to a rationalization of the process. When an orderly description has been made, the preparation of practictioners can be improved and the process more effectively interpreted to administrators and funding bodies.

A great deal of time and effort is spent by workers which duplicates what others have done or are doing. However, since an interchange about program developments only occurs among those who know each other, experiences are not shared widely. Shared experience does not mean indiscriminate adoption of ideas, plans, and materials, but rather adapting and building on what others have done.

If the well formulated and analyzed material is widely interpreted, administrators should have a better basis for deciding what kinds of patient education efforts should be supported and at what level. Perhaps some of the funds being spent on very questionable information giving or episodic endeavors could be redirected.

APPENDIX B

LIST OF PATIENT EDUCATION MATERIALS

1. Patient Education Program Evaluation*
2. Patient Education Coordinator - Position Description*

Source: Greenville General Hospital
and Greenville Hospital Center
701 Grove Road
Greenville, SC 29602

3. Southeast Region Health Education Program*

Source: Charles R. Drew Post Graduate
Medical School
1621 East 120 Street
Los Angeles, CA 90002

4. Diabetic Patient Education Program*

Source: St. Mary's Hospital and
Medical Center
450 Stanyan Street
San Francisco, CA 94117

5. Orientation Conference on Patient Education
6. Code of Patient Concern
7. Description of VA Medical District 14
8. Responsibilities and Functions of Patient Health
Education Coordinator - VA Medical District 14*
9. Patient Education Advisory Committee - Model*
Hospital Policy Memorandum
Criteria for Selection of Committee Membership
Subcommittee Patient Education - Diabetes
10. Patient Health Education Survey Forms With Instructions*
11. Planning for Specific Patient Education Programs*

Source: VA Medical District 14
Veterans Administration Hospital
2215 Fuller Street
Ann Arbor, MI 48105

*Included in Appendix C

12. Hospital Handbook's Descriptions of Responsibilities*
    Health Education Officer

13. Physician's Discharge Instructions*

    Source: U. S. Public Health Service Hospital
    Bay and Vanderbilt Streets
    Staten Island, NY 10304

14. Teaching Guidelines for Patients:
    Diabetic
    Cardiac
    Ostomy*

    Source: Employee and Patient Education Department
    Eastern Maine Medical Center
    489 State Street
    Bangor, ME 04401

15. Brochures:
    Patient Education Services
    Weight Control Clinic
    Diabetic Education
    Diabetes Education Workshops
    Diabetes Education Program Services
    Acne Clinic
    Cardiac Education
    Prepared Childbirth
    Hypertension Instruction*
    Enterostomal Therapy Services*
    Chronic Obstructive Lung Disease Instruction*

16. Catalog of Audiovisual Aids for Patient Education:
    (Chronic Obstructive Lung Disease and Diabetes)

17. Instruction Guidelines
    Laminectomy With or Without Fusion*
    Myelogram*
    Going Home Instructions Following Back Surgery*
    Pacemaker Teaching, Pre- and Post-operative
    Larynectomy - Pre-operative
    Cardiac Catheterization and Open Heart

*Included in Appendix C

18. Educational Assessment
    - Pre-operative Interview
    - Pediatrics
    - Operative Care Card
    - Ileostomy and Colostomy-Assessment and Teaching Check-off List*

19. Teaching Manuals
    - Diabetes
    - Chronic Obstructive Lung Disease
    - Cardiac

    Source: Carle Foundation Hospital/Carle Clinic
    611 W. Park Street
    Urbana, IL 61801

*Included in Appendix C

APPENDIX C

PATIENT EDUCATION MATERIALS

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2. Patient Education Coordinator - Position Description 40

3. Southeast Region Health Education Program 45

4. Diabetic Patient Education Program 62

5. Responsibilities and Functions of
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VA Medical District 14 69

6. Patient Education Advisory Committee - Model 72
Hospital Policy Memorandum
Criteria for Selection of Committee Membership
Subcommittee Patient Education - Diabetes

7. Patient Health Education Survey Forms With Instructions 77

8. Planning for Specific Patient Education Programs 81

9. Hospital Handbook's Descriptions of Responsibilities 89
Health Education Officer

10. Physician's Discharge Instructions 90

11. Teaching Guidelines for the Ostomy Patient 91

12. Brochures 96
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Chronic Obstructive Lung Disease Instruction

PATIENT EDUCATION MATERIALS -- Continued

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13. Instruction Guidelines 99

Laminectomy With or Without Fusion
Myelogram
Going Home Instructions Following Back Surgery

14. Educational Assessment 103

Ileostomy -- Assessment and Teaching Check-off List
Colostomy -- Teaching Check-off List

Greenville General Hospital (GGH) and
Greenville Hospital Center
Greenville, South Carolina

PATIENT EDUCATION PROGRAM EVALUATION

A. Diagnosis chosen for evaluation: Diabetes mellitus (newly diagnosed and uncontrolled)

1. Rationale - most frequently occurring diagnosis involving Patient Education Coordinators

B. Methodology of Evaluation

1. Establishment of Control Group by randomly choosing 40 case numbers from Patient Education Coordinators' Intake Files
2. Establishment of Random Group by random selection of 40 case numbers not included in Patient Education Coordinators' files or showing any documentation of patient education or discharge planning
3. Establishment of time period for study
   All cases were admitted during calendar year of 1974.
   Rationale - 1974 was first year of program; thus a Control Group could be established from records of Patient Education Coordinators' files.
4. Abstraction of data from the 80 Medical Records by Nursing Research Assistant and Assistant Director of Nursing at GGH (Member of Patient Education and Discharge Planning Coordinating Committee)
5. Calculation and analysis of data by same individuals mentioned in #3 (see attached data display)

C. Conclusions

1. The average patient age in the Control Group was significantly lower than in the Random Group.
2. There were almost three (3) times as many newly diagnosed diabetics in the Control Group than in the Random Group.
3. The number of insulin-dependent new diabetics in the Control Group was 27 and none of the new diabetics in the Random Group were insulin dependent.
4. The average length of stay for the Control Group was 3 days longer than for the random group.
5. Conclusions 2, 3, and 4 indicate that it takes longer to teach new diabetics and diabetics who must be taught insulin self-administration.
6. There was not a significant number of Control Group records showing Discharge Planning involvement to validate any impact on the length of stay by the Discharge Planning Program.

PATIENT EDUCATION PROGRAM EVALUATION - Continued

7. There were three times the number of readmissions (during the year) for diabetic control in the Random Group as in the Control Group.
8. Regarding readmissions for diabetic control, the Random Group required four and one-half times as many days of hospitalization as the Control Group.

D. Summary

Scientific evaluation of the first year of the Patient Education Program (focused only on the teaching of diabetics) reveals that those patients taught in the Patient Education Program have had a drastic reduction in the number of readmissions compared to the Random Group whose readmission rate was higher. Also, the Random Group patients who have been readmitted during the study year required a highly significant number of hospital days for control management. The Control Group readmission stays were lower (4-1/2 days less).

The study also shows that the Control Group patients' hospitalization stays average about 3 days longer than those patients who had no patient teaching. One of the reasons for this increased length of stay is the high number of new diabetics who are insulin-dependent and must be taught insulin self-administration as well as the pathophysiology and dietary aspects of the disease.

PATIENT EDUCATION PROGRAM EVALUATION - Continued

DATA DISPLAY

	Control Group	Random Group
Number of patients	40	40
Number of new diabetics	27	10
Number on insulin control	25	0
Number on diet and oral medication	2	10
Age range	7 - 80 yrs.	19 - 92 yrs.
Average age	37 yrs.	54 yrs.
Average length of stay	10 days	7 days
No other illness contributing to length of stay	29 patients (average length of stay - 10 days)	28 patients (average length of stay - 6 days)
Average day patient education began	3.7 days after admission	5.7 days after admission
Involved discharge planning	3 patients	0 patients
Readmissions for diabetic control	2 patients (length of stay - 2.5 days)	7 patients (average length of stay - 12 days)

Greenville General Hospital and
Greenville Hospital Center
Greenville, South Carolina

PATIENT EDUCATION COORDINATOR - POSITION DESCRIPTION

I. Location of Position

Staff Position - Nursing Service

II. Purpose of Work Performed:

To foster and coordinate the process of patient education through the services of patient care providers in order to enhance the ability of patients and families to understand and cope positively with health problems created or magnified by illness so that they may achieve and maintain an optimum level of health for successful return to the home setting or transition to a different level of care.

III. Nature of Work:

Instructional - 90 percent
Professional - 10 percent

IV. Major Responsibilities:

A. Coordinates the process of patient education as an integral part of quality health care:

1. Assesses capability of health care providers to meet educational needs of the patient.
2. In collaboration with health care providers plans educational activities in accordance with identified needs.
3. Insures the implementation of planned educational activities.
4. Evaluates the effectiveness of the process in meeting the patient's needs.

B. Collaborates with nursing service as the chief coordinator of patient care to:

1. Establish criteria for patient/family education by determining content, methods, and materials to be utilized in teaching:

a. Basic principles of health.
b. Specific disease entities.

2. Provide updating of knowledge, skills, or materials as indicated by:

a. Utilizing clinical specialists to teach staff the content of their specialties.
b. Reviewing principles of teaching-learning process as indicated.
c. Demonstrating methods of teaching.
d. Distributing appropriate teaching materials.
e. Evaluating effectiveness of teaching.
f. Recommending programs for further staff development.

3. Promote consistency in teaching concepts and teaching content applicable to health as well as health problems through:

a. In-service classes.
b. Orientation of new personnel to patient education program.
c. Mini-nursing unit workshops.
d. Ward conferences.

C. Collaborates with Social Service - Discharge Planners to:

1. Continually improve the coordination of patient education and discharge planning services.

2. Prepare a discharge plan for individual patients.

3. Interpret health problems as they relate to the patient's rehabilitation and lifestyle.

4. Serves as source of referral.

D. Collaborates with Medical Service to:

1. Provide assistance in evaluating health care problems and needs of patients and families.

2. Assist in meeting learning needs of patients and families.

E. Collaborates with Support Services:

1. Dietary

a. Assists in evaluating dietary needs in unique situations.
b. Reinforces dietary instructions.
c. Servs as source of referral.

2. Pharmacy

a. Exchanges information.
b. Promotes consistency in teaching content.
c. Schedules classes for group teaching.

3. Physical Therapy
   a. Promotes physical therapy teaching of staff.
   b. Reinforces physical therapy teaching of patient and family.
   c. Assists in evaluation of physical therapy needs of patients.
   d. Serves as source of referral.

4. Occupational Therapy

   a. Promotes awareness of availability and capability of this department.
   b. Serves as resource for teaching and for teaching materials.
   c. Serves as source of referral.

F. Collaborates with Community Services:

1. Home Health Services

   a. Promotes continuity of patient care through written and verbal communication.
   b. Promotes consistency in teaching by periodic evaluation of teaching materials and content.
   c. Serves as source of referral.
   d. Serves as a resource of information.

2. Vocational Rehabilitation

   a. Promotes awareness of availability and capability of this department.
   b. Serves as source of referral.

3. Volunteer Health Agencies

   a. Assists in the organization of programs as indicated.
   b. Promotes awareness of availability and capabilities of the various agencies.
   c. Serves as source of referral.

G. Participation:

1. Is a member of Greenville Hospital System Patient Education and Discharge Planning Committee.

2. Community Health and Welfare Services Planning

   a. Presents programs.
   b. Evaluates and recommends patient education materials.
   c. Recommends development of new teaching programs.

3. Regional and Statewide Health Planning Associations, Committees, and Programs

   a. Assists in organization and planning as indicated.
   b. Evaluates and recommends patient education material.
   c. Is a member of state society of patient educators.

4. National programs

   a. Serves as resource for development of programs in other institutions and organizations.
   b. Assists in organization and planning as indicated.

H. Administration:

1. Assumes responsibility for appropriate selection, utilization, and maintenance of equipment and supplies used in Patient Education Program.

2. Evaluates and acquires appropriate teaching materials as requested.

3. Prepares intermittent reports to reflect activities and status of progress.

4. Attends Nursing Administration meetings and gives reports as indicated.

I. Other

1. Directly teaches and counsels patients and families in unique situations where staff has been unable to achieve teaching-learning goals.

2. Conducts classes and conferences with nursing students in various programs upon request.

3. Reviews patients' medical records to insure appropriate documentation of patient/family teaching.

4. Assists in the production of new patient education materials as indicated.

5. Attends and participates in seminars and workshops.

V. Complexity of Work in Position:

A. Works within the South Carolina laws regulating the practice of nursing.

B. Works within the policies, procedures, and objectives of the Greenville Hospital System and the Division to which assignment is made.

PATIENT EDUCATION COORDINATOR - POSITION DESCRIPTION -- Continued

C. Makes significant contributions toward meeting the annual objectives set by Nursing Service and the Patient Education and Discharge Planning Coordinating Committee.

D. Serves actively on those committees to which assigned.

E. Accepts other responsibilities as assigned by the Director and/or Assistant Director of Nursing.

F. Continuously updates knowledge of biological and behavioral sciences as well as methods found to be most effective in the teaching-learning process.

VI. Extent of Supervision Received:

A. Reports to Assistant Director of Nursing - Staff Services.

B. Requires minimal supervision.

VII. Qualifications:

A. Bachelor's degree required - preferably in Nursing Science or in health education.

B. Graduate of an accredited school of nursing with current South Carolina licensure - mandatory.

C. Education and successful experience in the teaching-learning process.

D. Demonstrated skill in human relations.

E. Demonstrated evidence of continuing professional and personal development.

January 1976

Charles R. Drew Post Graduate
Medical School
Los Angeles, California

SOUTHEAST REGION HEALTH EDUCATION PROGRAM

I. INTRODUCTION

The Southeast Health Services Region includes Martin Luther King Hospital and four health districts: south, southeast, San Antonio, and Compton.

The population of Southeast Health Service Region at this time is approximately 764,957. It is largely a dependent population with 32 percent between the ages of 0-14 years and 8 percent above the age of 65. The median income is $7,754 annually as compared to $10,970 for Los Angeles. However, this does not truly reflect the nature of the poverty that exists. Thirty-nine percent of the population have incomes below the poverty level and approximately 21 percent of these people receive some type of welfare assistance. The population is mixed racially and culturally and is shifting from a large majority of Blacks to increasing numbers of Spanish surnames and others. These general conditions are reflected in the types of major health problems that exist in the Southeast Health Service Region.

Health education is that component of health and medical programs which consists of planned attempts to change individual, group, and community behavior with the objective of helping achieve curative, rehabilitative, disease-preventive and health-promotive ends. Health education is a process with intellectual, psychological, and social dimensions relating to activities which increase the abilities of people to make informed decisions affecting their personal, family, and community well-being. This process, based on scientific principles, facilitates learning and behavioral change in both health personnel and consumers, including children and youth.

This document proposes to address the issue of regionalization and coordination of health education. Included will be discussion on the present situation of health education in the Southeast Health Service Region and recommendations for change.

A. PROBLEM DEFINITION

Presently, there are 10.5 health educators in the Southeast Health Service Region. They are hired and function independently according to the needs and organizational structure of a particular hospital department, special project, or health district. Although there are many viable, ongoing health education programs and activities, there are none which are coordinated throughout the Region. In addition, some of the health educators are accountable to a different funding source. The aforementioned factors have led to divided loyalties,

limitations, lack of uniform priorities, duplication, and fragmentation of services on a regional level.

At this time, the health education manpower is concentrated in the Martin Luther King Hospital, the Drew School, Compton Health District, South and Southeast Health Districts. There is one district and several disciplines which are without health education programs and activities in those areas. Moreover, the lack of supportive manpower may result in inappropriate utilization of health educator's time.

Resources in the area of finance, media materials, and clerical support have not been adequately provided to all health educators in the Southeast Health Service Region. There are problems associated with acquisition of materials, budgetary approval, and technical consultation. This has resulted in limited development of needed health education programs and activities and new media materials. As a result of the rapid increase of the Spanish surname population as well as the existence of a large non-reading population, it is necessary to have resources to develop programs specific to the needs of those populations.

The major causes of death and disability in the Southeast Health Service Region are related to maternal and child health, trauma/accidents, and chronic diseases. These health needs must be dealt with in ambulatory care settings, inpatient settings, and in programs of community outreach. In fiscal year one, the major focus will be in ambulatory care settings. However, it is anticipated that a substantial amount of health education time will be spent in community education and outreach.

B. SCOPE

Southeast Health Region Health Education Services seeks to develop, implement, and evaluate a coordinated health education program for consumers living in the Southeast Region of the Los Angeles County Department of Health Services. The major outcome of this program will be the improvement of the health status and knowledge of individuals, families, and the community through health education programs that offer preventative measures, health promotion, and early detection; early diagnosis and treatment, curative measures, and prevention of disabilities; and prevention of further disabilities and rehabilitation. These programs will be integrated into the health care delivery system.

C. RATIONALE

Most major causes of sickness and death can be impacted by individual behavior. It is assumed that the individual can take some responsibility for the prevention and/or the outcome of his illness. In the

light of these assumptions, health education is defined as a process which increases the abilities of people to make informed decisions affecting their personal, family, and community well-being. This process facilitates learning and behavior change in both health personnel and consumers. It bridges the gap between health information and health practices providing the motivation for individuals and families to accept information and utilize it. Because the service area serves a diverse population, the health education programs will be based upon, and adapted to, the socio-economic and cultural needs of the population living in the Southeast Health Service Region. These programs will be developed utilizing the language of the populations served.

The health education programs of the Southeast Region are expected to extend existing programs and avoid duplication of services. It is also expected to assist in developing programs in areas that do not have such programs.

II. OBJECTIVES

2.1 To organize the health education services of the Southeast Region under a central coordinator to reduce duplication and fragmentation

2.1.1 Organize and convene a committee of health education personnel comprised of representatives from all districts, departments, disciplines, and special projects within the Region

2.1.2 Cooperatively develop a comprehensive health education for the Region

2.2 Determine health education needs within Southeast Region

2.2.1 Community profile
2.2.2 Information on morbidity and mortality
2.2.3 Perceived community needs
2.2.4 Existing resources

2.3 To establish teams of interested people from the MLK Hospital, Drew School, health districts, and community to plan, implement, and evaluate broad health education programs

2.3.1 Determine the present health education needs of the MLK Hospital, Drew School, district health centers, and community

2.3.2 Develop programs on high priority problems to match regional problems which will include programs on chronic diseases, women and children, accident and trauma, consultation, and ambulatory care

2.3.2.1 Develop basic format and guidelines for planning and implementation of the specific programs with projected cost

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued

2.3.2.2 Develop education packet for each program that contain the following: teaching objectives, learning objectives, educational materials, suggested evaluation materials, and suggested bibliographies

2.3.3 Preventive Health Education Teams will be organized for high priority subject areas

2.3.3.1 Provide health education consultation

2.3.3.2 Develop fliers, posters, brochures, and charts

2.3.3.3 Provide materials in Spanish

2.3.3.4 Provide services with a list of publications and information available in their subject area

2.3.4 Provide support and assistance for existing programs in the Southeast Health Service Region

2.4 To develop a mechanism for collecting, reviewing, cataloging, ordering, and distributing frequently used health education materials

2.4.1 Collect and catalog existing health education material

2.4.2 Develop new educational materials as needed for distribution to consumers and for specific educational programs

2.4.3 Establish protocol for a clearinghouse

2.4.4 Establish procedures for securing materials from the repository

2.4.5 Identify interested persons in the districts and hospital to be responsible for health education literature

2.5 To explore and develop innovative approaches to health education

2.5.1 Develop specific audio presentations on selected topics for our target population

2.5.2 Extend present educational programs by use of stations 3 and 6 on the present TV monitors in the hospital

2.5.2.1 Determine the resources necessary to make system operational

2.5.2.2 Develop videotapes for the system

2.6 To publicize health education as an important tool in the health care delivery system

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued

2.6.1 Publication of monthly reports on health education activities in the Region

2.6.2 Publish monthly consumers newsletter

2.6.3 Submit articles to Kaleidoscope

2.6.4 Secure space in local newspaper for regular health column

2.6.5 Involve interested consumers and staff in program planning and implementation

2.6.6 Radio and TV publicity for specific programs

2.7 To serve as a communication link between the health districts, hospital, other health providers, community residents, and organizations

2.7.1 Institute regular meetings with other health educators in the Southeast Region

2.7.2 Compile and catalog information regarding health services available in the Region

2.7.3 Organize presentations to be given at community meetings

2.7.4 Develop a Consumer Advisory Board

2.7.4.1 Patient Satisfaction
2.7.4.2 Grievance Procedure
2.7.4.3 Assist in establishment of program priorities

2.7.5 To publish materials on at least two of the following: How To Choose A Hospital, Primary Care Centers, Patients' Rights

2.8 To promote the development of health education as a concept and as a profession

2.8.1 Continued education for health education
2.8.2 Field training for health education students
2.8.3 Training health education assistants
2.8.4 In-service education for other health professionals

III. METHODOLOGY

3.1 Organizational Component

Southeast Region Health Education will be organized on a matrix structure. This component will describe the organizational relationships of the health education service to the Region, including

personnel, policies, procedures and protocol for the operation, and utilization of said health education services.

3.2 Educational Component

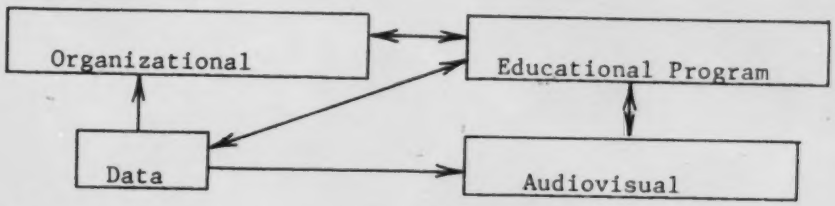
This component will contain an educational model which will be applied to the development of three specific educational programs to be designed within the next year. Each program will reflect the planning process and will include the scope, underlying assumptions, objectives, activities, evaluation, teaching aids, and cost factors for each of the three areas, and continuing support for existing programs. It will also contain activities related to staff training.

3.3 Audiovisual Component

This component will contain a model for collecting, compiling, and developing audiovisual materials needed to support all program components of the project. In addition, it will contain a listing of the elements needed for each programmatic area.

3.4 Data Component

This component will contain the reports on all studies and surveys specified in above objectives. In addition, it will contain the evaluation components of all implemented educational programs.



IV. NECESSARY STRATEGIES AND POLICIES

A. Interfaces

1. All providers of health services in the Southeast Region

2. Physicians
Work cooperatively with health educators in planning and implementing of all health education programs

3. Nurses
Work cooperatively with health educators to some degree in planning and to a greater degree in implementing health education

4. Social workers

5. Sanitarians
   Especially in outreach health education program

6. Other technical and supportive staff in specific educational programs as needed

7. Administrative personnel
   Work cooperatively in development of health education programs and staff

8. Community groups, organizations, and agencies

B. Policy Decisions Required

1. All policy decisions should be made by a joint consensus of Health Education Committee and the Regional Office

2. Director of Regional Health Education must be selected

3. Lines of authority and supervision must be clearly defined

4. Role of health educator in the region must be clearly defined

5. Specific roles and time allocation for identified projects must be clarified

6. Establish policies and procedures for procurring supplies and equipment necessary for programs

7. Relationships with district health offices and clinical chiefs must be clearly delineated

8. Roles and responsibility for each health education staff member must be clearly defined including job specifications and areas of responsibility

C. Decision-making Process

1. Policies will be developed by health education committee

2. Director of Health Education will submit policies to Regional Director for approval

3. Director of Health Education will have responsibility of assuring adherence to policies by all health education staff

4. Listed suggestions for health education priorities will be developed annually by health education committee and submitted for approval by regional administrative office

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued

V. PROGRAMS AND TASKS

A. Development of written regional health education programs

1. Formation of regional health education committee (July 1975)

2. Adoption of a format for planning

3. Submit first draft by October 1, 1975

4. Form subcommittees for detailed planning

5. Submit subcommittees' reports by November 20, 1975

6. Submit final draft to regional administrative office by December 5, 1975

B. Establish priorities within need areas previously stated

C. Determine schedule of activities - implementation of health education programs

1. Detailed plans for selected programs must be completed and approved by the committee by January 30, 1976. The programs should include: learning objectives, teaching objectives, suggested ongoing evaluation tools, suggested methods and materials, and suggested supplies and equipment

2. Select and acquire necessary materials and supplies for each program by February 10, 1976, depending on budget

3. Selection of sites for implementation must be completed by March 15, 1976

4. Implementation must have begun by April 1, 1976

5. Strategies for expansion of program must be submitted by July 1, 1976

D. Responsibilities for completion of program tasks are as follows:

1. Development of written program - acting regional chairperson

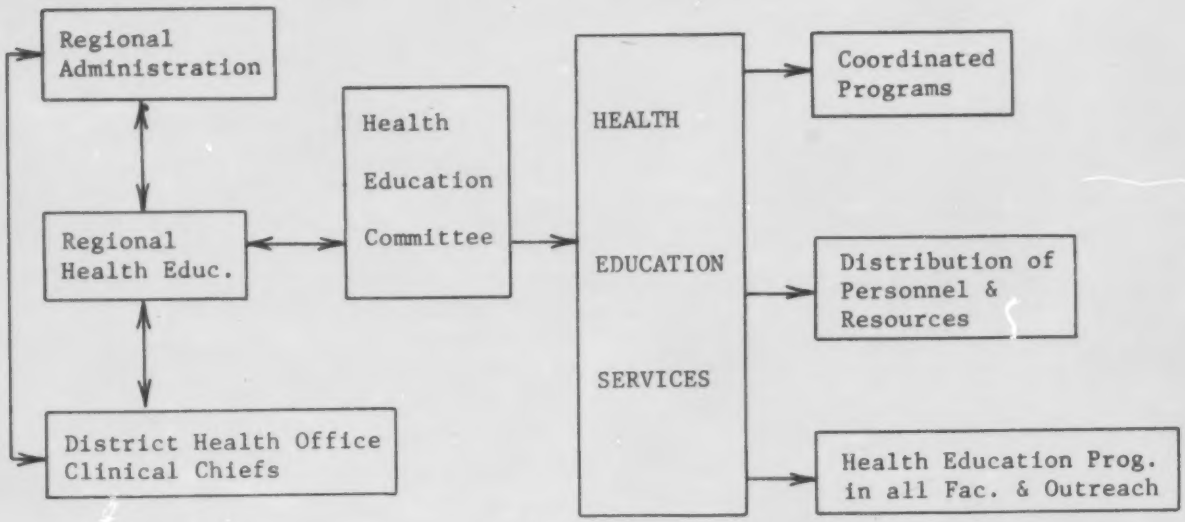
2. Statement of priorities - acting regional chairperson with regional health education committee consensus

3. Development of education packets - chairpersons of subcommittees

4. Implementation of programs - individual health educators through respective staff

5. Strategies for expansion - regional health educator with consensus of committee members

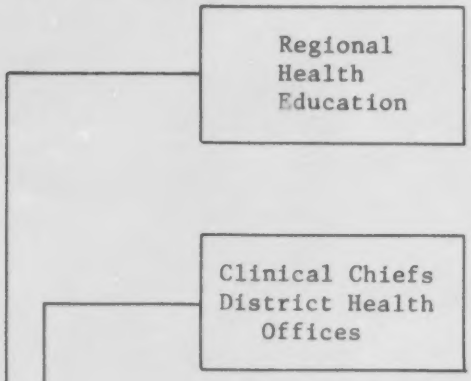
VI. ORGANIZATIONAL CONCEPTS



The organizational concept indicates the direction of the flow of information for program development and implementation. Program concepts and needs will originate through interaction of program people at the local and regional levels. The needs and concepts will be transmitted to the Health Education Committee which consists of all health educators in the Region. This Committee, assisted by input from the community, will establish the Health Education Services for the Region.

Such an approach to health education will result in coordinated programs, appropriate distribution of personnel and resources, and health education programs in all health facilities and community outreach programs.

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued



FUNCTIONAL OPERATIONS

At the functional level, programs will be conducted by the Matrix System of management.

STAFF PROGRAMS / HEALTH EDUCATORS	Consultation	Awareness in Ambulatory Care Setting	Family Health Women & Children	Chronic Disease	Accidents Trauma
Southeast (2)*					
South (2)					
San Antonio					
Compton (2)					
MLK Pediatrics (2)					
MLK Obstetrics Gynecology					
MLK Medicine					
MLK Surgery					
MLK Community Medicine					

*Indicates number of health educators in the setting

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued

The preceding portion of the health education proposal addresses itself to the process necessary for the development of a regionalized program. This portion of the report will consist of subcommittee reports. Each report will identify health education activities that are to be conducted in relationship identified broad categories of health-related activities.

Although specific learning objectives must be identified for broad categories, it is anticipated that community outreach and community organization techniques will be principal components of the strategy for implementation.

The four broad categories to be covered are:

1. Health Education for Ambulatory Care Settings
2. Family Health: Women and Children
3. Chronic Diseases
4. Consultation Services

The reports from the subcommittees are attached.

HEALTH EDUCATION FOR AMBULATORY CARE SETTINGS

GOAL

Provide educational programs which will encourage the citizens of the Southeast Region to assume responsibility for prevention of illness, maintenance of good health, early diagnosis and treatment, and prevention of disability.

GENERAL OBJECTIVES

1. Seventy percent of patients seen in ambulatory care settings will have participated in a health education program during the first year.
2. Committee approved health education programs will be conducted at least 20 percent of the time while clinics are in operation.
3. An identifiable committee approved program of patient education must be in progress by February 1, 1976.
4. Programs will be developed in the following areas:
   a. Nutrition including obesity
   b. Consumer awareness including access to services
   c. Immunization
   d. Dental health
   e. Sanitation and safety including personal hygiene
   f. Smoking and other preventive programs concerning substance abuse
   g. Sex education including V.D. and family planning
   h. Cancer
5. All programs will be planned in the format approved by the health education committee.
6. Programs will be developed and conducted in English and in Spanish.

PROGRAM PLAN FOR CONSUMER AWARENESS

Utilization of Services

I. Learning Objectives

1. Each person will be able to identify three services available at the facility.

2. Each patient will be able to identify procedure for getting access to facility and/or physician services.

3. Each patient will be able to identify the steps in making appointments and cancelling appointments.

4. Each patient will be able to list three reasons why it is important to keep appointments.

5. Each patient will be able to identify the nearest emergency care center.

6. Each patient shall have a list of members to call in case of an emergency.

7. Each person will be able to process his own complaints.

8. Each person will be able to identify a referral source to other community services.

II. Teaching Objectives

1. Provide information about all clinic services and for whom, where, and when--post and give clinic schedule.

2. Provide information which states procedure for obtaining a clinic appointment.

   a. Referral
   b. Phone call
   c. Walk in

3. Discuss methods for cancelling and making appointment.

   a. Information needed to give:

      1. Patient identification number, if available
      2. Name of physician
      3. Name of clinic

   b. Telephone number and extension to call

c. Calling hours

4. List of reasons it is important to keep appointments.

   a. Advantages to patient

      1. Continuity of care
      2. Positive image of patient to clinic personnel

   b. Advantages to clinic

      1. Permits efficient scheduling
      2. Allows for proper utilization of time
      3. Permits better control of materials and supplies

   c. Advantages to others

      1. Provides regularly expected openings
      2. Allows other persons to receive services

5. Provide information, location, and telephone number of:

   a. Rescue Squad

      1. Compton
      2. Los Angeles
      3. Lynwood
      4. Los Angeles County
      5. Paramount

   b. Nearest emergency facility

      1. St. Frances
      2. Martin Luther King
      3. Others

   c. Kinds of services available (call hospital at primary, secondary or tertiary emergency center)

   d. Cardio-Resuscitation Unit - Los Angeles City Heart Association

6. Provide information on complaint procedure

   a. Teach patient bill of rights
   b. Explain questionnaire and suggestion box to patient
   c. Discuss the use of the questionnaire
   d. Identify complaint recipient
   e. Discuss resolution of complaint
   f. Provide feedback mechanism to patient

7. Provide information on other available services in the community.

   a. Drug and Alcohol Programs
   b. Mental Health
   c. Parks & Recreation
   d. Head Start

III. Strategy for Evaluation

1. Pre & Post Test

2. Number of grievances filed

3. Degree to which learning objectives were actually met

IV. Methods and Materials

1. Methods

   a. Small group discussion
   b. Role playing
   c. Demonstration
   d. Lecture
   e. Questions and Answers

2. Materials

   a. Paper and pencils
   b. Clinic schedule - without telephone numbers
   c. Patient bill of rights
   d. Questionnaire and complaint form
   e. Suggestion box

V. Supplies and Equipment

1. Poster Board

2. Magic markers

3. Film and projector

4. Sound on slide

5. Literature

6. Tape and recorder

SOUTHEAST REGION HEALTH EDUCATION PROGRAM -- Continued

CHRONIC DISEASE EDUCATION

I. INTRODUCTION

The committee for chronic disease patient education has met and decided on the priority areas for community education in the Southeast Region over the coming year. They are as follows:

1. Hypertension
2. T.B.
3. Substance abuse
4. Diabetes

The following report will briefly outline the major goals and objectives for these programs.

II. HYPERTENSION PROGRAM

2.1 Overall Goal: To increase consumer awareness about the dangers of uncontrolled hypertension in the Southeast Region

2.2 Major Objectives

2.2.1 To develop a publicity campaign about high blood pressure to reach 50,000 consumers residing in the Southeast Region within one year at a cost of _____.

2.2.1.1 Radio, T.V.
2.2.1.2 Printed media (newspapers, fliers, etc.)

2.2.2 To educate, through mass media approaches, 50,000 consumers residing in the Southeast Region as to the seriousness of uncontrolled high blood pressure

2.2.2.1 Uncontrolled high blood pressure can lead to heart damage, stroke, kidney damage, and death

2.2.2.2 There is only one way to find out if you have high blood pressure - get your blood pressure taken

2.2.2.3 If you have high blood pressure, see your doctor and do what he tells you

2.2.3 To make consumers, residing in the Southeast Region, aware of where they can go to get their blood pressures checked

2.2.3.1 Private physician
2.2.3.2 Hospital/clinic/agency
2.2.3.3 Special screening projects

2.2.4 To develop an evaluative tool to measure consumer awareness of the dangers of uncontrolled high blood pressure

2.2.4.1 Survey questionnaires
2.2.4.2 Phone survey
2.2.4.3 Other approaches

2.2.5 Develop pre-packaged programs in hypertension

St. Mary's Hospital and Medical Center
San Francisco, California

DIABETIC PATIENT EDUCATION PROGRAM

FLOW CHART

Physician Prescribes Patient Education

Assessment of Patient by Each Team Member
(Nurse, Dietitian, Pharmacist, Social Worker, Pastoral Care)

Team Conference*

Teaching by Team Members

2nd Team Conference w/Physician

Follow-up After Discharge

*Copy of minutes sent to patient's physician.

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DIABETIC PATIENT EDUCATION PROGRAM -- Continued

PROCEDURES

Orders

When a diabetic patient is admitted to the Unit, Head Nurse asks patient's physician whether he/she would like patient in the teaching program.

If yes -

1. Head Nurse asks physician to write "diabetic patient education" as order.
2. Head Nurse asks physician to complete Physician's Order Sheet.
3. Head Nurse then informs Paient Education Office and suggests convenient time for Team Meeting to be held.

If no -

Patient Education staff member will visit Unit each week to obtain data on non-referrals.

Assessment

4. Patient Education Office notifies other team members (dietitian, pharmacist, and social worker), and schedules team meeting.

5. Head Nurse designates nurse to interview patient and to assess patient's educational needs.

6. Team meeting is held, at which information is shared regarding patient's regimen and educational needs. Subjects to be taught and responsibility for teaching are determined.

Teaching

7. Each team member instructs patient, using Lesson Outlines and Patient Fact Sheets, as a basis.

8. Prior to patient's discharge, Head Nurse contacts physician to arrange second team meeting with physician present.

9. Head Nurse notifies Patient Education Office as to when second team meeting can be held.

10. Patient Education Office schedules second team meeting with other team members.

11. Second team meeting is held--Team reports on teaching progress and makes recommendations for follow-up as appropriate.

12. Copies of team meeting minutes for patient's files are mailed to physician.

Revised 9/10/74

DIABETIC PATIENT EDUCATION PROGRAM -- Continued

PHYSICIAN'S ORDER SHEET

Please circle the appropriate designation(s).

My patient is to be controlled on

1. INSULIN THERAPY.
2. ORAL DRUGS.
3. DIET.

I would like my patient by the time of discharge in _____days to:
(please give approximate number)

Date Ordered

(Please circle designated categories)

A. Attain general information about diabetes.

B. Follow diet according to instruction.

C. Test urine.

D. Understand and administer insulin.

E. Understand function and action of oral drugs and possible interaction with other drugs.

F. Know what to report to doctor.

G. Know when to call doctor.

H. Follow good health practices: foot, dental, eye, and skin care.

I. Understand own feelings about disease and be able to adjust to every day activities (travel, job, exercise).

J. Have family members included in the education (please specify which member).

K. Learn about other community resources.

L. All of the above.

M. Special instructions or comments: _____

_____

_____

July 1, 1973

_____ M.D.
Physician's Signature

DIABETIC PATIENT EDUCATION PROGRAM -- Continued

Newly Diagnosed Diabetic Patient Assessment

Patient's Name_____ Family Member _____

Interview Date_____

Physician's Name_____ Interviewed by _____

Primary Diagnosis_____

Age_____ Physical Handicaps_____

Date of Diabetes Onset _____ Language Problems_____Yes _____No

TIME STARTED:_____TIME ENDED:_____

Comments:

1. Do you know what diabetes is?

_____

_____

_____

2. Do you know how diabetes is controlled?

_____

_____

_____

3. What were your symptoms of diabetes?

_____

_____

4. Has anyone in your family had diabetes?

_____

_____

5. Can you put into words how you feel about diabetes?

_____

_____

_____

February 7, 1974

NEWLY DIAGNOSED
PATIENT ASSESSMENT

Comments

6. Does it make you feel you're different from other people?

_____

_____

7. Do you think it increases your sensitivity to others?

_____

_____

8. What was it like for you when the doctor first told you that you have diabetes?

_____

_____

_____

Initial Observations

Circle one

Frame of mind: Anxious, Depressed, Puzzled, Inattentive, Angry, Fearful, Nonchalant, Attentive, Friendly, Cooperative.

Verbal comprehension: Excellent, Good, Fair, Poor, Unknown

Time: _____mins. DIABETIC PATIENT EDUCATION PROGRAM -- Continued

Present:

TEAM CONFERENCE

Date:_____ Patient's Name:_____

Age:_____ Location: (Unit & Room)_____

Date Onset
of Diabetes:_____ Physician's Name:_____

Reason for Hospitalization:_____

Social Data:

Medical Data:

Assessments by

Nurse:

Dietitian:

Pharmacist:

Social Worker:

Recommendations:

DIABETIC PATIENT EDUCATION PROGRAM -- Continued

SECOND TEAM CONFERENCE

Time:
Present: Date:_____ Patient's Name:_____

Age:_____ Location: (Unit & Room)_____

Teaching Experience: Physician's Name:_____

Teaching Experience:

Nursing:

Dietary:

Pharmacy:

Social Service:

Recommendations:

Nursing:

Dietary:

Pharmacy:

Social Service:

Additional Comments:

Veterans Administration Medical District 14
Ann Arbor, Michigan

RESPONSIBILITIES AND FUNCTIONS OF PATIENT HEALTH EDUCATION COORDINATOR - VA MEDICAL DISTRICT 14

The Patient Health Education Coordinator (OOE) is responsible for overall planning, organizing, and directing of Patient Health Education for Medical District 14.

The functions of the Patient Health Education Coordinator are:

I. Consults and provides in-service education on Program Planning for Patient Education.

   A. Program Planning includes the following steps:

      1. Needs assessment or documentation
      2. Program development
         -Program objectives
         -Selection of appropriate education methods
         -Selection and/or development of appropriate educational materials
      3. Program implementation and follow-up
      4. Program evaluation

   B. Serves as advisor and assists program staff in developing, pre-testing, and utilizing patient health education material and programs connected with their specific programs.

   C. Provides technical guidance and direction in the preparation and development of patient health educational materials and procedures.

   D. Advises on the development of the most effective and productive patient health education approaches, methods, and media required.

   E. Interprets the research in patient health education and evaluates the educational approaches to be considered in the light of cultural, economic, environmental, and social factors affecting health education practices and attitudes.

II. Enhances and strengthens the coordination and development of Patient Education Programs by:

   A. Establishes an effective procedure for requesting patient education for VA beneficiaries for home use following discharge from the hospital, utilizing existing community, county, state, and federal resources. (PHN Coordinator)

RESPONSIBILITIES AND FUNCTIONS -- Continued

B. Serves as consultant to hospital administration and professional services in developing planned, coordinated patient health education services on a district basis.

C. Maintains an active patient education program schedule in cooperation with staff members and field stations on a district basis.

D. Participates with appropriate program and clinical specialists in the stimulation and organization of patient health education programs (Field Station Patient Education Committee).

E. Coordinates and integrates on district basis patient health education plans and projects with those of other patient education programs (District Patient Education Committee).

III. Consults and participates with field stations to insure that an effective patient education program is implemented and its operation is of high quality.

IV. Collaborates with federal, state, county, and community organizations concerning the need for quality patient health education programs and resources.

V. Consults and participates with voluntary and private organizations and colleges and universities regarding research, training, and program development in patient health education.

VI. Functions as preceptor for graduate students who have special interest and backgrounds in patient education.

A. Holds an appropriate faculty appointment in the School of Public Health at the University of Michigan.

SUPERVISION AND GUIDANCE

Patient Health Education Coordinator is under the general direction of the Medical District 14 Director, VA Hospital, Ann Arbor, and performs independently with a minimum of supervision.

Direction is provided by Veterans Administration Central Office, Department of Medicine and Surgery, and by Program Consultant, Program in Health Education, School of Public Health, University of Michigan.

Program Guidelines will be developed.

OTHER SIGNIFICANT FACTS

The Patient Health Education Coordinator must provide leadership, identify areas of need, obtain active participation, develop channels of communication, educate, demonstrate, and advise.

RESPONSIBILITIES AND FUNCTIONS -- Continued

Performance of the Patient Health Education Coordinator requires much insight, judgment, initiative, and follow-through for successful conduct of the program.

Special emphasis is on multidisciplinary collaboration.

An essential characteristic of the Patient Health Education Coordinator is the ability to deal satisfactorily with other people at all levels.

VA Medical District 14

PATIENT EDUCATION ADVISORY COMMITTEE - MODEL

HOSPITAL POLICY MEMORANDUM No. 00-00 June x, 1975

PURPOSE 1
POLICY 2
DEFINITIONS 3
MEMBERSHIP 4
RESPONSIBILITIES 5
MEETINGS 6
REFERENCES 7
RESCISSION 8
DISTRIBUTION 9

PATIENT EDUCATION ADVISORY COMMITTEE

1. PURPOSE: To establish a multidisciplinary advisory committee to develop a systems approach for the coordination of health education programs in the VA Hospital,_____.

2. POLICY:

   a. Establish a (Hospital) systems approach for the planning, implementation, and evaluation of defined patient education programs.

   b. Establish defined (planned, coordinated, evaluated) educational programs to meet the health education needs of all eligible consumers who seek care from the Veterans Administration Medical System.

3. DEFINITIONS:

   a. Patient Health Education Program is a defined educational plan for the individual patient, group of patients, and/or hospital system. The defined plan establishes a set of objectives (or patient outcomes) sufficiently detailed to allow evaluation of the effectiveness of the plan and/or the education intervention.

   b. Health Education is a process of growth in an individual which increases his/her ability to make informed decisions about one's health as a result of planned learning experiences. The objective of all health education is to promote the individual and/or family members to think, feel, and act wisely on matters pertaining to health and illness. Health education involves motivation, communication, and decision making.

   c. Patient Health Education or simply Patient Education refers to the educational experiences planned for the patient by professional personnel as a component of his/her care and distinguishes these experiences from unplanned learning experiences in the hospital and from other organizational or environmental factors which influence his/her behavior.

4. MEMBERSHIP:

a. The Patient Education Advisory Committee is designed on a multidisciplinary basis to recognize and promote the viewpoints, roles, functions, and contributions of the health care team members in policy decisions concerning planning and implementation of defined patient education programs.

b. Members may substitute an alternate when unable to attend a committee meeting. The alternate will have the full power and authority to speak and/or vote for the member who is absent.

c. (List Committee Members. It is strongly suggested that the members be chosen on a multidisciplinary basis and be chiefs of services in order to best promote and recommend policy for the patient education program.)

5. RESPONSIBILITIES: The Patient Education Advisory Committee is charged to:

a. Stimulate the awareness of and involvement in planned patient education programs.

b. Identify needs for patient education.

c. Select priorities among the needs.

d. Establish and assign subcommittee responsibility for development of specific programs.

e. Approve patient education program proposals.

f. Recommend resource allocation for patient education program.

g. Monitor implementation of patient education programs.

h. Insure review and evaluation of patient education programs.

6. MEETINGS: The Patient Education Advisory Committee will meet on a regular monthly basis, or when called by the Chairman.

7. REFERENCES: Program Guidelines for Patient Education in the VA System are currently being developed. The final draft is expected to be finished and approved by the Chief Medical Director, VACO, by the end of FY 1976.

8. RESCISSION: None.

9. DISTRIBUTION: A

CRITERIA FOR SELECTION OF COMMITTEE MEMBERSHIP

PATIENT EDUCATION ADVISORY COMMITTEE

- Committee structure should be multidiscipline not multi-service. The committee should not have more than 25 percent of any one discipline.
- Committee structure should be made up of decision-makers, thus chief-of-service level.
- Committee member should supervise or direct providers who have patient teaching responsibilities...i.e., the provider is responsible for delivering patient education activities.
- Committee structure should be large enough to be representative of the major service areas that have responsibility for patient education activities and small enough to be functional as advisors to hospital director. (Not over 15 people)
- Committee member should have a positive interest and motivation to improve the quality and coordination of patient education activities.
- Committee chairperson should be selected on basis of ability and power to provide support to improve the quality and coordination of patient education activities.

DIABETIC PATIENT EDUCATION - SUBCOMMITTEEE

1. PURPOSE: To establish a multidisciplinary planning committee to develop planned and coordinated patient education activities for the management of Diabetes mellitus.

2. POLICY:

   a. Establish a model for planning, implementing, and evaluating patient education activities in VAH.

   b. Establish a planned education program to meet the health education needs of the diabetic patient and his family.

   c. Establish an educational delivery system which could be applied to future education programs as well as to the program for diabetic patients.

3. MEMBERSHIP:

   a. The Sub-Committee for Planning Diabetic Patient Education Activities has been selected on a multidisciplinary basis to insure that the responsibilities and contributions of all health care team members are recognized in implementing patient education activities.

   b. The planning committee for diabetic patient education activities is a subcommittee of the Patient Education Advisory Committee and the membership will be as follows:

   COMMITTEE:

   Chairperson
   Member
   Member
   Member
   Member
   Member
   Member

4. RESPONSIBILITIES: The planning committee for diabetic patient education is charged to:

   a. Identify the problems and needs of the diabetic patient served by VAH.

   b. Develop a planned patient education program for the disease entity Diabetes mellitus for VAH.

   c. Develop a delivery system for VAH, to implement the diabetic patient education activities.

   d. Plan and implement staff training, if indicated.

VA Medical District 14

PATIENT EDUCATION ADVISORY COMMITTEE - MODEL -- Continued

e. Develop mechanism(s) to evaluate the diabetic patient education activities.

5. MEETINGS: The planning committee for diabetic patient education will meet on a regular basis.

6. REFERENCES: NONE

7. RESCISSION: NONE

Dist:

VA Medical District 14

PATIENT HEALTH EDUCATION SURVEY FORMS WITH INSTRUCTIONS

General

1. The following directions are issued as a part of the Patient Health Education Activity Survey. The information requested on the survey forms was determined by a panel of VA experts in patient health education as being important in establishing baseline data.

2. The "Patient Health Education Activity Survey," VA Form 10-5369 (Test) will be used for this survey. These forms are being printed and will be sent in quantities sufficient for your hospital.

3. Survey forms are to be completed by knowledgeable persons in all services in your hospital by October 1, 1975.

4. Comments and suggestions relating to this survey are solicited.

5. If there are any questions, please call _____.

PART I

1. This part of the survey is to be completed for each patient education activity that currently and routinely occurs in your service. Fill in the name of your hospital, name of your service (Dietary, Nursing, Dentistry, Physical Therapy, Chaplaincy, Voluntary, Pharmacy, etc.), and the date of this report.

2. Educational Activity:

   This can be planned or incidental, formal or informal in nature. For example: Diabetic teaching may be a planned, formal program taught by person(s) from one or more services, in which case you would write "Diabetic Teaching" in this space. Or, it might be that patients are taught various aspects of diabetic care as part of their routine care from your service. For this you would write, for example, "insulin injection" or "diabetic skin care" or "diabetic diet", as the case may be, in this space. Other examples might include such things as "activities of daily living", "crutch walking", "colostomy care", "low sodium diet instructions", etc.

3. Approximate Number of Patients/Month:

   Place in this space the approximate average number of patients participating in this educational activity per month.

VA Form 10-5369(Test)
September 1975

4. Approximate Number of Hours/Month:

   In this space place the approximate number of total hours per month devoted to this educational activity.

5. Number and Category of Teachers:

   How many persons are involved in this educational activity per month (on the average)? The term "category" denotes the titles of the persons involved in the teaching. For example, in Rehabilitation Medicine, there might be a P.T., O.T., R.T., etc., involved; in Nursing, R.N.'s, L.P.N.'s, or N.A.'s might be involved.

6. Questions Relating to Educational Activity:

   All of these questions relate to the specific educational activity listed. If you have any explanatory remarks or need additional space, use the back of the page.

   1. Check as many responses as apply.
   2. Self-explanatory.
   3. If the response is "Yes", check as many as apply.
   4. Self-explanatory.
   5. Self-explanatory.
   6. If the response is "Yes", check as many as apply.

PART II

Fill out this part of the survey only once for your service. List the patient education priorities for your service, with the most important being #1. These activities may already be in existence, planned, or hoped for. List as many or as few priorities as you wish.

PATIENT HEALTH EDUCATION ACTIVITY SURVEY

PART I

PLEASE COMPLETE THIS PAGE FOR EACH PATIENT EDUCATION ACTIVITY IN YOUR SERVICE

Hospital_____ Service_____Date of Report_____

EDUCATIONAL ACTIVITY	APPROXIMATE NUMBER OF PATIENTS/MONTH	APPROXIMATE NUMBER OF HOURS/MONTH	NUMBER AND CATEGORY OF TEACHERS NUMBER	CATEGORY

QUESTIONS RELATING TO EDUCATIONAL ACTIVITY

1. How do patients become involved in this activity?

   ___ As part of routine care
   ___ Doctor's order
   ___ Patient request
   ___ Other (Specify) _____

2. Is there a written course outline (teaching plan) for this activity?

   ___ No
   ___ Yes (Please include a copy with this report)

3. Is the level of the patient's learning determined?

   ___ No
   ___ Yes, through:

   ____Outcome measures
   ____Return demonstrations
   ____Ability to answer questions
   ____Other (Specify) _____

4. Has the educational activity itself been evaluated?

   ____No
   ____Yes
   How has it been evaluated?

   _____

5. Are family members included in this activity?

   ____Never
   ____Sometimes
   ____Always

6. Is this educational activity recorded?

   ___No
   ___Yes

   ____In patient's chart
   ____In ward (unit, service) records
   ____Other (Specify) _____

VAForm 10-5369(Test)
September 1975

PART II

LIST THE PATIENT EDUCATION PRIORITIES, IN ORDER OF PRIORITY, FOR YOUR SERVICE.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

*List as many or as few as you wish.

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM*

The Program Design Components are as follows:

I. Pre-planning Data necessary to develop design components

II. Instructional Design**

III. Delivery Design**

IV. Staff Training Design**

V. Evaluation Design**

*The subcommittee for planning will be assigned the responsibility of program design. The subcommittee may need consultant(s) who has expertise in selected areas such as the problem or disease entity, educational methodology, media production, staff training, evaluation methodology, etc.

**The subcommittee will include in the design a listing of the resources necessary to implement each of the components.

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

I. Pre-planning Data:

-Identify pertinent characteristics of target population (patient profile for selected problem area or disease entity)

Review health care facility statistical records

Review medical records

Personal interview(s) with providers and consumers

-Develop flow chart for target population to identify (Admission to discharge; outpatient activities; home care activities)

Locations patients come into contact with health personnel

Type of personnel who come into contact with the patient

Amount of patient waiting time involved

Number of patients in one place at one time

Available space for teaching purposes

-Review current patient education activities related to selected target population.

How is patient teaching being carried out presently?

How and when does patient teaching get introduced or initiated?

Does the physician order patient education as he does other treatment modalities?

Does the provider assess the patient's educational needs? How?

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

Who has the responsibility for teaching patients? Do the patient teachers have adequate teaching skills? How do you know? How much time is given to teaching patients and family members by patient teachers?

Is the educational process a planned one? Who plans it? How? How consistent is the message given by the different patient teacher(s)?

How and in what way is the family involved? What plans are made for reinforcement and follow-up support?

Are teaching/learning activities routinely recorded in the patient's medical record? Where? By whom?

Is the patient's educational progress evaluated? How?

If the patient is discharged before the educational needs are met, is there a mechanism for completing the educational process? What?

Does a mechanism exist for teaching patients on an out-patient basis? Home care basis?

-Identify sources and review existing patient education programs

Has a systems approach been developed and implemented for the problem or disease entity selected? By whom? Where?

What have commercial companies developed in this area for patients? Is it on the market? Where are the commercial products being used? Have they been evaluated for effectiveness? By whom? Is there a report on the results? Are the costs reasonable? Does the commercial product lock the hospital into an inflexible hardware, software system?

-Review and understand the etiology and general management patterns of the problem or disease for that health care facility.

Individual Study (literature review, etc.)

Group Study (workshop, consultation, etc.)

Develop model of patient care patterns

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

-Review and become familiar with potential patient education resources outside the health care facility.

Determine availability of resources

Will the resources meet the stated objectives and patient needs?

Can VA utilize the resources effectively? What are the barriers to utilization?

II. Instructional Design

-Educational process (teaching/learning activities)

List all possible content areas (topics)

Develop statement(s) of learning objectives (behavioral objectives; expected outcomes)

Select program content (finalize content area)

Select appropriate methods

Select or develop learning resources (educational materials)

Printed materials for patients
Instructor's Guide and materials
Audiovisual materials

Develop format for learning process (teaching time, frequency, sequence, assignment of content by discipline(s), etc.)

Develop standard(s) for evaluation (see Evaluation Design)

-Identify and select instructors. As a guide, patient teacher(s) should possess:

Knowledge of the problem or disease, or potential for development of such knowledge.

Education skills, or potential for development of educational skills (communication skills, group skills, skills needed to implement program design)

A commitment to patient teaching role

Willingness to work with other team members

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

-Identify resources necessary to implement this component (who or what, how many, location)

Patients/families - target population

Providers/staff - teaching team

Space

Equipment

Software/hardware

Materials

-Instructional design should be put into writing by the subcommitte

III. Delivery Design*

-Develop mechanism** for receiving order from physician(s)

-Develop mechanism** for learning about the education needs of individual patients

-Develop mechanism** for making educational plan for individual patient

-Develop mechanism** for implementing education plan for individual

-Develop mechanism** for recording educational activity in the medical record

-Develop mechanism** evaluating the individual patient's progress

-Develop mechanism** for continuing educational process after discharge, if needed...i.e., outpatient basis and/or home basis

-Delivery design should be put into writing by the subcommittee

*Parts of a delivery design may already exist in the health care facility. If the existing mechanism meets the delivery design described, use them.

**Each mechanism should include the process to implement and the tools to implement.

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

IV. Staff Training Design

-Plan staff training

Assess needs (why train)

Specify learning objectives

Introduction of change
Review program design for selected problem or disease entity
Establish commitment for systems approach to patient education
Develop skills related to the educational process

Design Learning Activities and Select Resources

Participants	Format
Trainers	Dates
Consultants	Food and Refreshments, if needed
Methods	Travel, if needed
Materials	Accommodations, if needed
Space for training	

Develop mechanism to evaluate the training session(s) (for example, pre-assessment, post-assessment, follow-up assessment, etc.)

-Identify resources necessary to implement this component

Develop mechanism(s) for getting selected staff into training

Develop mechanism(s) for conducting staff training

Setting up for the training session(s)
Setting the learning climate
Directing the learning activities

-Staff training design should be put into writing by the subcommittee.

V. Evaluation Design*

-Plan evaluation

Statement of learning objectives (developed in the Instructional Design)

Identify methods to assess objectives

Develop assessment/measurement tools

Develop procedure(s) for collecting data

Develop procedure(s) for tabulating, summarizing, and analyzing data

Develop mechanism(s) to formulate conclusion and recommendations

Report evaluation results

Modify program design based on conclusion(s)

-Identify resources necessary to implement this component

-Evaluation Design should be put into writing by the sub-committee

*Evaluation, a circular process, is an integral component of instructional design and determines the amount of success in achieving predetermined objective. Evaluation is essential to the determination of success at the patient and program levels. The primary purpose of evaluation is to provide information for decisions about programs. Its results are useful for program improvement decisions, not just for continuation or termination decisions.

PLANNING FOR SPECIFIC PATIENT EDUCATION PROGRAM -- Continued

-Evaluation design should include feedback on such elements as:

Education process:

Patient outcomes (knowledge, skills, attitudes)

Educational methods

Educational materials

Patient/teacher outcomes (knowledge, skills, attitudes)

Delivery process:

Introduction or initiation of patient education (order)

Requisition for implementation (referral process... i.e., in and out of hospital)

Scheduling of teaching/learning activities

Teaching/learning activities

Record of teaching/learning activities in patient's record

U. S. Public Health Service Hospital
Staten Island, New York

HOSPITAL HANDBOOK'S DESCRIPTIONS OF RESPONSIBILITIES FOR

Health Education Officer

The Health Education Officer serves as a consultant in the planning and execution of coordinated health education services for inpatients, outpatients, employees, and community agencies and organizations. He/she stimulates hospital staff to give greater priority to the performance of educational tasks essential to the provision of personal health services. He/she serves as a resource to staff by aiding the "health team" in developing and appraising the educational component of health services. He/she takes leadership in identifying and assessing resources available that may be utilized in the educational activity to be undertaken. He/she aids hospital staff in planning and execution of the health education aspects of pre-service and in-service training programs. He/she stimulates hospital personnel to incorporate effective health education practice into their daily work.

In the community, the Health Education Officer participates in or conducts educational programs in cooperation with Parent-Teacher Associations, Headstart, voluntary health agencies, civic organizations, Golden Age Clubs, schools, Community Action Programs, hospitals, colleges, and religious groups. He/she assists in the establishment and maintenance of cooperative working relationships between those agencies and citizen groups which might contribute to health education of the public. He/she participates in planning or conducts community discussion groups, institutes seminars, work shops, etc., related to health protection and promotion. He/she serves as a liaison between the community and the hospital, and interprets community services provided by the hospital.

On request, the Health Education Officer serves as consultant to voluntary and official state and national health organization staff on planning, development, and implementation of education programs in medical care settings. He/she participates in seminars, conferences, and workshops at state and national levels to promote the development of patient education programs.

USPHS Hospital

DRAFT

PHYSICIAN DISCHARGE INSTRUCTIONS
(Please Print)

DATE:

PROBLEM(S):

1. 4.

2. 5.

3. 6.

DISCHARGE MEDICATON(S): (Drugs, dosage, amount, frequency) (No abbreviations-Use Generic Names)

PURPOSE(S) OF MEDICATION(S): (Layman's terms)

ACTIVITY: (e.g., climbing stairs, driving car, sexual relations, lifting, bathing, contact sports, return to work, etc.)

DIET:

INSTRUCTED BY:

SPECIAL INSTRUCTIONS: (e.g. dressing changes, special exercises, self administration of medications, adverse effects of drug combinations)

MAJOR SIGNS AND SYMPTOMS WHICH SHOULD BE REPORTED TO A DOCTOR (Related to this hospitalization):

FOLLOW-UP APPOINTMENT:
(If Applicable)

We have discussed these instructions together and the information is understood.

Signature of Patient or Guardian

Signature of Physician

Patient Identification

Register No.	Ward No.

Original to: Patient's record
cc: Patient

Physician Discharge Instructions
Form No.

Employee and Patient Education Department
Eastern Maine Medical Center
489 State Street
Bangor, ME 04401

TEACHING GUIDELINES FOR THE OSTOMY PATIENT

Objectives:

1. Provide consistent care through planning, communication, and patient and family instruction.
2. Provide hope and sense of security through independent care.
3. Help patient accept self through Visiting Committee of the local Ostomy Association.
4. Help patient in resumption of social and occupational roles through proper utilization of community resources.
5. Enable the patient and family to learn about stoma care and living.

Teaching Aids:

"Colostomies: A Guide"

"Living Comfortably with Your Ileostomy"

"Urinary Ostomies" (A Guidebook for Patients)

"Caring for Your Colostomy" (Filmstrip)

Equipment Display

Teaching Team:

Physician
Enterostomal Therapist
Staff Nurses

Outline:

The following is an outline which can be used to teach the patient and his family basics of Ostomy Care and individualized therapy. Together, the patient, family, and teaching team should establish a realistic plan for the future.

TEACHING GUIDELINES FOR THE OSTOMY PATIENT -- Continued

Diagram in Book

I. Normal Anatomy and Physiology
   A. Normal small and large intestine
   B. Function of each

Anatomical Trip across Abdomen

II. Anatomical Changes
   A. Reason for changes
   B. Change in function
   C. Terminology of ostomies

III. Immediate Post-operative Daily Care
   A. Reassurance that E.T. will be in daily
   B. Application of pouch
   C. Skin problems
      1. Reason
      2. Ways to prevent
   D. Emptying and cleaning of pouch
   E. Colostomy Irrigation
      1. Height of container
      2. Use of cone or catheter
      3. Time for insertion of water
      4. Time allowed for expulsion of water and feces
      5. Care of equipment
   F. Management of odor

IV. Involvement of patient and family during recuperative phase
   A. Reassure patient that he will become self-dependent
   B. Encourage participation in appliance hygiene
      1. Temporary appliance - open ended: rinse with lukewarm water, change on regular basis.
      2. Permanent appliance - Emptying and methods of cleaning and airing.
      3. Use of various preparations taken internally to reduce odor or preparations for use in the ostomy appliance.
   C. Colostomy irrigation
      1. Principles involved in irrigating.
      2. Reasons for irrigating as opposed to free drainage.
      3. Demonstration to and redemonstration by family member.
      4. Care of equipment

   D. Urinary stoma care
      1. Importance of fluid intake
      2. Control of fungus growth
      3. Control of odor
      4. Appliance hygiene

V. Preparation for discharge
   A. Review previous instruction in stoma care
   B. Obtain an ostomy visitor from the local Ostomy Association
   C. Encourage participation in the local Ostomy Association
   D. Discuss bathing, swimming, and travel
   E. Discuss physical set up of home and use of bathroom.
   F. Discuss care of posterior wound if appropriate.
   G. Provide patient with necessary supplies and name and address of company where he can purchase them.
   H. If possible have patient dress before discharge to demonstrate type of clothing worn.

VI. Refer Patient to Appropriate Community Agencies.

VII. Emphasize the Importance of Follow-up.
   A. Refer to the Stoma Clinic for re-measurement of stoma and skin inspection.
   B. Discuss fitting to a permanent appliance if applicable.
   C. Discuss "normal" expectations with the ostomy and how to cope with signs of difficulty.

TEACHING GUIDELINES FOR THE OSTOMY PATIENT -- Continued

OSTOMY PATIENT - ASSESSMENT OF TEACHING

Instructions: (1) After initial interview, indicate educational needs of the patient and/or family.

(2) Initial and date all entries - REMEMBER: This does NOT replace patient progress notes.

Content	Needs	Instruction given	Comprehension and/or Satisfactory Demo.	Comments
Anatomy and physiology of digestive tract				
Surgical anatomical changes 1. Terminology explanation				
Participation in viewing and touching stoma				
Explanation of appliance used. 1. How to measure stoma for fit. 2. How to open and close closure clamp. 3. How to empty and clean 4. When to change				
Colostomy irrigation 1. Reason for 2. Principles involved 3. Care of equipment				
Odor control 1. Appliance preparations 2. Internal preparations 3. Cleanliness				
Skin problems 1. Common causes 2. How to avoid 3. Preparations available to treat				

TEACHING GUIDELINES FOR THE OSTOMY PATIENT -- Continued

Content	Needs	Instruction given	Comprehension and/or Satisfactory Demo.	Comments
Care of posterior wound (if applicable) 1. Use of drainage pads 2. Sitz bath explanation 3. Healing process				
Urostomy care 1. Cause of fungal growth and how to treat it 2. Cause of crystal formation and how to treat 3. Importance of fluid intake 4. Use of night drainage 5. Presence of mucous threads in urine				
Discuss activity after discharge 1. Bathing, swimming 2. Travel				
Referral to visiting committee of local Ostomy Association 1. Encourage to join local group				
Provide patient with supplies and name and address of purchasing co.				
Refer to discharge planning if home follow-up is necessary				

Carle Clinic/Carle Foundation Hospital
Urbana, Illinois

HYPERTENSION INSTRUCTION
GROUP SESSIONS

Do you have questions about hypertension, such as:

_____What is hypertension and what does it mean to me?

_____Are medications important in controlling blood pressure?

_____Is a special diet necessary for me?

_____Am I getting enough exercise?

_____Should I smoke?

It's normal for you to have many such questions. We hope that through a well-planned educational program you will have these and many other questions answered.

Are there classes on hypertension which you can attend?

Yes, The Carle Clinic Association is offering group classes for the individual with hypertension. Family members are also encouraged to attend. A registered nurse conducts the sessions. You may attend as many sessions as you feel are necessary to sufficiently understand your condition.

How do you register for instruction?

Appointments may be made at the West-6 desk or by calling_____.
Appointments must be made prior to attending the classes.

Where and when are the classes held?

The classes are held twice a month - the first and third Monday of each month at 8:30 a.m. They meet in the Lab Classroom on the 7th floor of the Clinic.

What topics are covered at the classes?

1. General discussion on hypertension
2. Importance of controlling hypertension
3. Contributing factors - heredity, smoking, obesity, emotional stress, etc.
4. Complications of untreated hypertension
5. Treatment plan - medication, diet, reduction of stress, and smoking
6. Balanced exercise

ENTEROSTOMAL THERAPY SERVICES

A NEW COMMUNITY SERVICE As an ostomate, you may find your recent change in body function to be socially and emotionally distressing, and often difficult to manage. But with proper teaching and guidance, you may also find that your surgery need not be a deterrent to work, marriage, travel, and recreation. You can learn to function effectively with a stoma and continue to enjoy life.

To help the ostomy patient in this endeavor, Carle Clinic has developed a new service in enterostomal therapy. Enterostomal therapy is a relatively new field of specialization, developed in the 1960's, to provide quality of teaching and care for the ostomy patient. Our service is a community resource that is prepared to meet the ostomate's particular needs after he has left the hospital. The service is designed for the teaching, rehabilitation, and long-term follow-up of the stoma patient.

WHAT WE OFFER Carle Clinic's certified enterostomal therapist, who is also a registered nurse, gives the following objectives for ostomy instruction:

(1) To teach self-care and management;
(2) To review and expand previous orientation in self-care;
(3) To select proper appliances;
(4) To control gas and odor;
(5) To establish and maintain good skin care;
(6) To provide emotional support;
(7) To aid in additional resources if necessary;
(8) To provide long-term support.

The service does not seek to duplicate existing services in the community such as the Ostomy Association, American Cancer Society, or family agencies. Enterostomal therapy service at Carle Clinic deals primarily with the rehabilitative aspects of proper stoma and appliance management and care.

HOW TO ENROLL Although Carle Clinic is sponsoring this program, you need not be a Carle patient to enroll for instruction. Any ostomy patient may avail himself of this service. The ostomy instruction is conducted in the Colon/Rectal Surgery department of Carle Clinic at East-3. Appointments may be made by calling. There is a minimal fee, and family members may accompany you.

Enterostomal therapy is a very important part of your post-surgical care and will assist in your total recovery. Please let us help. If you'd like more information about enterostomal therapy, ask your physician, or give us a call.

Carle Clinic/Carle Foundation Hospital
Urbana, Illinois

CHRONIC OBSTRUCTIVE LUNG DISEASE INSTRUCTION

Whether it be asthma, chronic bronchitis or emphysema, patients suffering respiratory diseases have one thing in common: They must learn to live with their disease if they are to live as normal and full life as possible. Helping patients to realize that goal is the reason behind a coordinated program of individualized teaching activities currently being offered by Carle Clinic and Carle Foundation Hospital.

Your personal physician will refer you to Chronic Obstructive Lung Disease Instruction on an out-patient basis. An appointment, made at the Main Appointment Desk of Carle Clinic, will allow you to see a registered nurse for a single teaching session. If you are hospitalized, this teaching is also available to you.

The Chronic Obstructive Lung Disease program is tailored to meet your individual needs. A family member is encouraged to attend the teaching session so that he can learn the principles of good home care along with you.

If you have any further questions about this program, please call Patient Education Services.

All of the following topics will be discussed with you at your intruction session:

(1) General discussion of C.O.L.D.
(2) Nutritional considerations
(3) Taking prescribed medication
(4) Avoiding respiratory irritants
(5) Preventing respiratory infections
(6) Starting an activity program
(7) Postural drainage
(8) Diaphragmatic breathing

Carle Clinic
Urbana, Illinois

INSTRUCTION GUIDELINES

LAMINECTOMY WITH OR WITHOUT FUSION

_____Instruct patient that they will have an ECG and chest x-ray before surgery if over age 40.

_____Explain purpose of the enema and lab work. A type and cross-match will be done and blood will be ordered (usually 2 units).

_____Explain purpose of the pre-op physical and that he may have nothing by mouth for a period of time prior to surgery. A pre-op medication will be given about 1 hour before leaving his room for the operation room.

_____Tell him he will be shaved and scrubbed with iodine soap or Phisohex from the shoulders to the buttocks to lessen the chance of infection.

_____Have patient demonstrate "log role," how to void while lying down and deep breathing exercises. Explain that the bed will be flat during the entire hospital stay.

_____Post-operatively, the patient will go to PAR. He will awaken with an oxygen mask with mist; and IV will run for 24-48 hours.

_____Upon return to room, vitals will be checked every 4 hours and turned every 2 to 4 hours. He will be encouraged to move lower extremities frequently; dressing will be checked frequently.

_____Ice chips are permitted upon return to floor and liquid diet that night.

_____Explain to patient that medication for pain and nausea will be available. Encourage him to ask before he is extremely uncomfortable.

_____No urinary catheter will be inserted unless necessary.

_____Usual activity - dangle 2nd day, and ambulate 2nd or 3rd day; activity will be gradually increased.

_____Dressing will be changed about 3rd or 4th day.

_____Explain that patient may have muscle spasms; if so, his physician wil order medication for comfort.

_____Gas pains may also be present because of bed rest: heating pad and rectal tube will be available to relieve this and enema on 3rd day.

_____Explain Intermittent Positive Posture Breathing procedure. (IPPB)

_____Explain that a catheter may be in the operative site and will be attached to Gomco suction. This is to prevent a hematoma. It will be removed in 24-48 hours. There is no discomfort while tubing is in place, but there is a brief burning sensation when it is removed.

INSTRUCTION GUIDELINES -- Continued

MYELOGRAM

_____Ask patient if he is allergic to iodine. Have him sign operative permit. Explain that he may have nothing to eat or drink after 10 a.m. and he may get a pre-operative medication.

_____Tell to patient that he will be taken to the x-ray department in the Clinic building by wheelchair or cart and returned to his room via cart.

_____Explain to patient that a lumbar puncture will be done and dye will be injected. He will lie prone on a table for the x-rays. The table will be tilted to help the dye circulate through the spinal canal.

_____The procedure takes between 1 to 2 hours.

_____Encourage the patient to lie flat until the following morning to prevent possible headache. Additional hospitalization may be required if headache occurs.

_____Encourage adequate oral intake to prevent headache.

_____Explain when results of exam will be available.

_____If the patient is in pelvic traction prior to x-ray, it is usually not continued afterwards.

GOING HOME INSTRUCTIONS FOLLOWING BACK SURGERY

Dressings: Dressings are usually not necessary after discharge from the hospital Wear loose clothing to prevent irritation on the incision. If a dressing is desired, apply gauze pads which can be purchased at any drug store.

Bathing or showering: You may resume these after your stitches are removed. If you are Dr. _____patient, you should shower only.

Walking: Gradually increase the amount of walking you do at home, either in the house or (if weather permits) outside on level ground. Avoid wet or slippery ground. Walk briskly and increase your walking to 3-4 miles daily.

Sitting: Sit on firm chairs. Avoid overstuffed furniture which would not give your back support. Sit for only short periods of time at first. Increase the time you are sitting gradually as comfort allows. You will find that the sitting position puts the most strain on your back, so spend most of your time either lying down or walking the first few days you are at home.

Rest periods: Plan several times during the day when you lie down to rest. At first, you may need 3-4 periods per day. The need for these will decrease as you regain your strength.

Stairs: You are permitted to go up and down stairs, if necessary, but take your time in climbing them and avoid stairs when possible.

Automobile trips: (1) If you live an hour or more away from Carle Hospital, make at least 5-10 minutes walking before resuming your trip. Frequently, people are more comfortable on the trip home if they flex or bend their hips and knees while riding. You can do this on the trip home by placing a small pillow under your thighs and knees while sitting on the car seat. (2) Once you are home, limit your riding to trips that are absolutely necessary. Ask your doctor for instructions as he may wish you to refrain from riding entirely. You may ride in the automobile for your return appointment with your doctor. Do not undertake any long automobile trips without consulting with your doctor. (3) Do not drive until your doctor instructs you that you may do so.

Return to work: Check with your doctor. This will be determined by your type of employment, and how far you live from work. You can assume that you will be off work at least six weeks to 3 months, and possibly longer. After a spinal fusion heavy labor may have to be avoided for 6 months.

Lifting: Do not lift heavy objects. Do not bend or stoop over to pick up objects on the floor. Do not pick up small children. You may hold them on your lap for short periods of time. Have someone place the child on your lap and take them off for you.

Household chores: (1) Laundry - this is permitted only if it is not necessary for you to lift or carry laundry baskets. (2) Dusting - light dusting is permitted. Again, only if stooping is not involved. (3) Bed making - refrain from this, since this requires bending. (4) Mopping and waxing floors - again, refrain from this chore. (5) Cooking - this is permitted as

long as you do not overtire yourself and if your counters are a height that keeps you from stooping while preparing a meal.

Diet: No restrictions! Resume normal diet; until your activity is back to normal, you may want to restrict your food amount slightly to prevent weight gain.

Bowel function: Again, until your activity is back to normal, you may have some constipation difficulty. Include fruit juices and roughage (fresh fruit and vegetables) in your diet. If this is not sufficient to prevent constipation, you may take milk of magnesia as a laxative.

Sexual activity: Consult with your doctor as to when you may resume your usual sexual activity.

Bracing: Consult your physician if this is necessary and for how long.

Carle Clinic
Urbana, Illinois

ASSESSMENT AND TEACHING CHECK-OFF LIST

ILEOSTOMY

NAME_____AGE_____RACE_____

PHONE_____ADDRESS_____

CLINIC #_____OCCUPATION_____

EDUCATIONAL BACKGROUND_____

* * * * * * * * * * * * * * * * * * *

Physician (Carle)_____Referring_____

Patient Educator_____Interview Date_____

In-Patient / / Out-Patient / /

History

1. Diagnosis_____
2. Type of surgery_____Date of Surgery_____
3. Diet_____
4. Activity_____
5. Medications_____

_____

6. Other medical problems_____
7. Socioeconomic factors_____

EDUCATIONAL ASSESSMENT -- Continued

ILEOSTOMY

		Patient	Family Member	Comments
Lesson 1	Knowledge of Condition			
	a. Basic anatomy and physiology			
	b. Type of ileostomy			
	c. Rationale for ileostomy			
	d. Information pamphlets			
Lesson 2	Ileostomy Care			
	a. Ileostomy equipment			
	1. Permanent			
	2. Disposable			
	b. Procedure for appliance change			
	c. Care of equipment			
	d. Appliance covers			
	e. Emptying			
Lesson 3	Skin Care			
	a. Principles for protection			
	b. Treatment for irritation			
	c. _____			
Lesson 4	Dietary Considerations			
	a. Foods to avoid			
	b. Salt and water needs			
	c. _____			
Lesson 5	Medications			
	a. Effects of			
	b. _____			
Lesson 6	Additional Considerations			
	a. Control of			
	-leakage			
	-odor			
	-gas			
	-diarrhea			
	b. Activity			
	c. Job			
	d. Sexual activity			
	e. Ostomy Association			

EDUCATIONAL ASSESSMENT -- Continued

COLOSTOMY

		Patient	Family Member	Comments
Lesson 1	Knowledge of Condition			
	a. Basic anatomy and physiology			
	b. Type of colostomy			
	c. Rationale for colostomy			
	d. Information pamphlets			
Lesson 2	Colostomy Care			
	a. Colostomy equipment			
	b. Procedure for irrigation			
	c. _____			
Lesson 3	Skin Care			
	a. Adhering agents and skin protectors			
	b. Treatment for irritation			
Lesson 4	Dietary Considerations			
	a. Foods to avoid			
	b. _____			
Lesson 5	Medications			
	a. Effects of---			
	b. _____			
Lesson 6	Additional Considerations			
	a. Avoidance of: -odor, gas -diarrhea -constipation			
	b. Interpersonal relationship -close family -friends -sexual relations			
	c. Vocational -school or work			
	d. Avocational -hobbies -sports and travel -Activities			
	e. Ostomy Association			